A Preventative Intervention:
Staff Experiences Providing Harm Reduction in the Niagara Region

By

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Abstract

Harm reduction is a pragmatic philosophy and practice within health care which emphasizes disease reduction and social accessibility of health services over law enforcement and judicial punishment for drug use. There is a breadth of literature studying the impact of harm reduction practices on clients, but little on the people who facilitate these services. This project uses a political economy of health theoretical approach to examine the role of harm reduction and harm reduction workers within neoliberal state frameworks. Using an interpretive-critical analysis of qualitative interviews, this project highlights an NEP servicing the Niagara Region as a site of resistance to neoliberal restructuring which is also constrained by its policies. By providing public health care and referral to external resources such as housing, the site acts as a form of retrenchment from the neoliberal state while still being hindered by precarious labour and austerity policies in relation to funding. A key finding is that workers engage in emotional labour, boundary negotiation, and debriefing to offset burnout to better perform their labour, which is an unspoken but necessary part of the job. The findings of this research lay the foundation for future research in harm reduction labour and operation as well as emphasizing the blend between service and health care work that is necessary for effective harm reduction practice.

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Chapter 1 - Introduction

Harm reduction is a range of public health policies designed to reduce the harmful consequences associated with various human behaviours, both legal and illegal. Although there is little consensus on the exact definition of harm reduction, it can be described as non-moralistic, practical, non-judgemental, evidence based, and standing in contrast to abstinence based approaches to drug use as they do not require a reduction in drug consumption as part of their mandate (Hobden & Cunningham 2006; Strike et al 2002; Boyd et al 2008). In the area of drug use, these programs can take the form of needle exchanges, methadone maintenance programs, facilities such as safe injection sites, and many others. While there are a wealth of studies analysing the effects of harm reduction practices from a quantitative perspective in addition to the demographics of their clients, Canadian qualitative data concerning the workers themselves is sparse. Studying the experience of harm reduction workers produces research pertinent to multiple disciplines including sociology, health sciences, and labour studies, while providing access to insight that may not be produced through research concerning their clients alone. Furthermore, the data gathered through this project could be used to refine existing harm reduction practices, influence public policy concerning them, and highlight its benefits. Given this, this project sought to explore one facet of harm reduction, the experiences of the staff members providing these services. This question is subdivided into further questions stemming from existing themes in the literature based on harm reduction and its provision in order to attain a qualitative sociological perspective on harm reduction practices and the lived experiences of both those who provide these services.

This research is informed by harm reduction discourse, noted above, as an approach that seeks to redefine drug use not as a criminal phenomenon but as a health issue, which can be

mitigated through effective responses facilitated by trained staff who share this perspective. As opposed to incarceration or penalty, harm reduction seeks to use strategies outside of the criminal justice system in order to address detrimental effects associated with drug use, especially high risk drug use such as sharing used equipment which may spread disease. While this often occurs only through relatively small scale, fixed site locations such as supervised injection sites or needle exchange programs, significant gains have been made in recent years in the realm of policy. For example, Portugal decriminalized the use of illicit drugs in 2000 in favour of a health-oriented strategy which redirected resources into administrative and harm reduction initiatives rather than criminal justice and incarceration (Goncalves, Lourenco, & Silva 2014). This policy direction has been found to decrease the social cost of drug use both in the realm of legal proceedings and in general health (Goncalves, Lourenco, & Silva 2014).

More than ever, research on harm reduction is critical to understand and respond to the quickly developing opiate crisis in Canada and North America in general. The Canadian Government has released data indicating that in 2017 there were 2458 opioid-related deaths in Canada which is likely under-reported as data from Quebec was not available (Government of Canada 2017). While the government data indicates the issue is most prevalent in British Columbia, Ontario has seen a dramatic increase as well. Opioid related deaths in Ontario have risen from 127 in 1991 to 550 in 2010, with deaths occurring every three to four days between 2011 and 2013 (Strike & Miskovic 2017). Citing recent research, Maclean's magazine reported that that there were 676 overdose deaths in 2014 alone in Ontario, significantly higher than even the 481 road fatalities that had occurred that same year (The Ontario Drug Policy Research Network 2017).

The unprecedented amount of deaths caused by opiates has consequently led to the increased popularization and implementation of several safe injection site initiatives in Ontario. Toronto has declared that three safe injection sites will be opened in the city citing the over 100,000 client visits to harm reduction sites and 1.9 million needles distributed across the city as evidence for the necessity of such sites (City of Toronto). Furthermore, the mayor of Hamilton Fred Eisenberger has endorsed the opening of a safe injection site in his city, and Health Canada has approved the opening of a safe injection site as well, thus demonstrating increased interest in and viability of such sites being opened in major cities (Carter 2016, Willing 2017). Some are not waiting for official capacity to facilitate these safe injection sites however, with unsanctioned "pop-up sites" being operated by harm reduction workers in Ottawa and Toronto despite possible legal repercussions (Blackmore 2017, Rider 2017). With harm reduction workers on the front line driving forward initiatives such as safe injection sites, it is all the more pertinent that research be performed to understand and document the work they do, their perspectives, challenges, and what can be improved upon.

While some research has been performed investigating the workers themselves who carry out these harm reduction initiatives, notably the work of Strike et al (2002) in which researchers gathered data on the meanings ascribed to needles by harm reduction workers, there is a significant gap in the literature. Many questions remain as to the nature of their work, the benefits and barriers they encounter, their interaction with the police and state figures, and how they relate to the clients themselves who use these services. Thus, the purpose of this research was to gather data in order to address this gap and act as a foundation for future research. With harm reduction growing as a practice and industry, evidenced by the future establishment of injection sites in Toronto and possibly Ottawa, more research will be needed in order to fully

define the best practices to be utilized in these initiatives, and to highlight areas for improvement from the workers' perspectives (The Canadian Press 2017).

Considering this, the study presented here seeks to ask, "what are the experiences of harm reduction workers in the Niagara Region?", focusing specifically on a single site, an ASO with an associated NEP that operates in their building and services this locale. This is further divided into more specific sub-questions such as: how do the staff describe the service(s) being offered and their experience working for the Needle Exchange Program? How do the mobile outreach services operate and how do the clients know how to identify their vehicles? What is the relationship between different staff members and clientele? How do interactions and relationships with the police affect harm reduction practices? What strategies are unique to the research site that may be absent from the literature? Has the political climate in which harm reduction practices occur changed since the recent 2015 Federal election? And lastly, how do the staff and organization engage with clients who do not speak English or French or may not be from the region? While these questions shifted slightly during the course of this research — for example, data gathered that highlights cultural and religious outreach were included under the final question listed here — the questions aided in guiding this research and organizing data for the purposes of this study.

Beyond this introductory chapter, this thesis is divided into four chapters. In chapter two, I will outline the existing literature on harm reduction and factors that may arise throughout the study that could be pertinent to the research participants' experiences. This serves as a means not only to establish a literature-based foundation from which to work, but also highlights how the research questions have been designed and the concepts around which they are oriented. These topics include service provision, accessibility, public and staff opinion, police and state issues,

emotional labour and boundary negotiation, the benefits of harm reduction work, and the barriers that may be encountered. Furthermore, a list of terms that will be used throughout the thesis will be provided.

The third chapter will highlight the methods and methodology utilized in this project, in addition to the data analysis process. This will include the theoretical underpinnings of this research, intersectional feminism and risk-environment framework, and how these have been integrated within the project and used as an epistemological foundation. Methodologies to be discussed include interpretive and critical methodology, whereas methods sections include describing the interview type to be utilized, ethical considerations, recruitment, sample selection, and general methods. Lastly, the data analysis procedure will be elaborated upon, including the first axial, and selective rounds of coding, ending with an overview of the limitations involved with these processes.

The fourth chapter includes the findings, organized by the research sub-questions that they pertain to. These involve the services offered and general experiences of the workers, the mobile outreach service, the relationship between staff and clients, interactions with police, unique strategies used to implement services, the political climate in which workers perform their labour, and how the needle exchange program is organized to be more accessible to people of different cultures, religions, and languages. A wide variety of testimony from the participants have been interspersed throughout this section in order to provide a direct account of the topics discussed in this chapter.

Lastly, the fifth and final chapter engages with a discussion based on the findings in relation to the literature, in addition to general conclusions. Furthermore, this chapter includes the limitations encountered throughout this project, and final thoughts on ethical considerations

and the issues that arose during the research process. Finally, this will be followed by a conclusion and possible areas for future research that could use this study as a foundation to investigate questions pertaining to harm reduction workers in more detail, or on a greater scale than was possible given the constraints of this project.

Chapter 2 - Literature Review and Common Themes

This section provides a thematic map to concepts common in the literature relating to harm reduction in Ontario, Canada in order to situate this project in the existing research. Literature was gathered using Brock Supersearch and ProQuest using terms such as “needle exchanges”, “harm reduction”, and “Ontario” in varying combinations. Articles reviewed are English language only and published after year 2000 in order to ensure relevance. Themes included are service provision, accessibility, public and staff opinion, police and state issues, emotional labour and boundaries, benefits of harm reduction services, and barriers to their provision, operation, and expansion. As research on harm reduction workers themselves is sparse, these themes are used in order to highlight the environment they work in, the equipment they use and dispense, and the challenges they may face. Additionally, this information is very significant in generating appropriate interview questions to be used later in the research process.

Service Provision

The most common theme among harm reduction research is a description of the material services provided which seek to fulfil the mandate of harm reduction in some capacity. These can take various forms including but not limited to NEPs, SISs, SCUK programs, and Naloxone distribution programs. This section will outline these services and their expressed purpose.

NEPs are services that provide sterile equipment in an effort to reduce the amount of sharing between PWID in an effort to stem disease transmission and reduce the number of injuries resulting from re-used equipment that can become damaged or dulled after a single use. Additionally, NEPs can act as disposal sites for used needles and other materials that could be considered biomedical threats to public and personal safety. The first NEP opened in Ontario in 1989 and since then additional sites have been effective at fulfilling their mandate of both

provision and disposal, evidenced by the fact that in 1998 Ontario NEPs distributed 859,474 new needles and received 875,164 needles for disposal (Strike et al 2002a). Since then, over 36 NEPs have opened in Ontario and it was the first province in Canada to implement a province-wide program providing injection related supplies in addition to other materials at no cost to NEPs (Strike et al 2014). The first NEPs, and some still operating to this day, rely on a one-for-one needle exchange — one in which a PWID is given only an amount of needles matching the number they return for disposal (Strike et al 2002a). This model was adapted for several reasons — it was rushed into implementation with inexperienced staff who had limited evidence to base their practices on, it seemed the least likely to be met with opposition from the general public, and it ensured distribution numbers matched return numbers which was used as a metric of efficacy (Strike et al 2002a). As mentioned above, NEPs in a fixed location can also be used to provide space for counselling, phone referrals, and storage of extra supplies for utilization by the NEP (Strike 2002b). Additionally, NEPs can act as a contact point for PWID to access drug treatment programs, health care services, and education regarding drug use and harm reduction (Milson 2003). Lastly, NEPs and other harm reduction services generally offer condoms as well for the same purposes of preventing disease transmission, with 2006 research indicating that approximately two-thirds of harm reduction agencies offered free condoms (Hobden & Cunningham 2006). These however are low level interventions and can be supplemented with more intensive services such as SISs.

SISs are fixed site locations that act as “legally sanctioned and supervised facilities designed to reduce the health and public order problems associated with illegal injection of drugs” (Strike et al 2014, p.946). The first such location opened in the Netherlands in the 1970s with an additional 92 opening since then in 61 countries worldwide including Germany,

Switzerland, Spain, Australia, and Canada (Strike et al 2014). The most prominent and only example in Canada is that of Insite, which opened its doors in 2003 and continues to operate in Vancouver, British Columbia to this day despite significant pushback from the Federal Conservative Federal Government from 2006 to 2015. Services aim to create highly accessible interventions that improve the health and safety of a PWID without requiring any reduction in actual drug consumption (Shaw et al 2015). Research shows that Insite not only prevented *at least* 35 new cases of HIV and nearly 3 deaths a year but also provided cost savings over $6 million per year *after* costs are taken into account (Andresen & Boyd 2012). Insite's own statistics state that on average there are eight overdose interventions each day, with 1,781 interventions in 2016 alone, thus demonstrating the extent of the ongoing opiate crisis and necessity of such services. While SIFs are adept at serving PWID, they do not address those who use smoking as their method of choice rather than injection, and so SCUKs are utilized to fill this gap.

SCUKs are kits that include materials that can offset the risk of disease contraction that may be present in those who share paraphernalia meant for smoking drugs rather than injecting. While the kits are primarily geared towards those who use freebase cocaine or 'crack', the equipment can be used for any drug that is consumed through smoking and is thus applicable to a number of contexts. While the first SCUKs only provided mouthpieces and push sticks they did not include any sort of pipe or glass stem (Ivsins et al 2011). This is no longer the case, as current kits include a heat resistant Pyrex glass stem, mouthpiece that can be attached and detached, a push stick for cleaning and manipulation without touching hot equipment, brass screens, and health information (Ivsins et al 2011). The mouthpiece can be considered the key component in this kit as it not only prevents burns from contact with hot glass, it also allows

each individual consumer to have their own mouthpiece that they can attach to a stem or pipe in the case they need to share. This can prevent disease transmission from sharing saliva, or blood if either or both of the consumers have mouth or lip wounds. While clean equipment can offset disease, it will not prevent overdose and thus medical interventions such as Naloxone need to be offered when an SIS is not available.

Naloxone is a "safe and effective opioid reversal agent that has been used routinely in hospital and prehospital settings" (Leece et al 2013, p.200) and is offered through NEPs such as "The Works" in Toronto and "the NEP" in the Niagara Region (Leece et al 2013). The substance essentially reverses an overdose caused by opioids such as heroin, morphine, and oxycontin to name a few in order to stabilize the victim until medical attention can be sought. The kits contains two one millilitre ampoules of Naloxone Hydrochloride, three syringes with one-inch safety-engineered needles, a Naloxone Prescription Identifier Card, instruction pamphlet, and alcohol swabs (Leece et al 2013).

Service provision therefore can include supplies, services, locations, and interventions aimed at reducing drug related harm to clients and recipients. Although these interventions listed above have been proven effective, they need to be accessible to clients in order to produce the desired results of disease and overdose prevention.

Accessibility

Whereas the previous section detailed *what* is provided, this section will cover *how* these services are accessed or provided. While SISs only operate at a fixed location at this point in time NEPs have the opportunity, and arguably, an obligation to find ways in which accessibility of their services can be improved. This is due to the fact that PWID tend to avoid service providers until a crisis emerges because they find these interactions to be "humiliating,

unhelpful, and offered in locations and at times not compatible with their lives (Strike 2002b, p.340). This has resulted in three additional services going beyond the fixed site: mobile services, satellite services, and in home services. Mobile services are offered by about two-thirds of Ontario based NEP services, and often operate out of a vehicle belonging either to the NEPs or the service workers themselves (Strike 2002b). Newer services tended to rely on worker vehicles, and for safety reasons members always go two at a time. PWID are able to find this vehicle through specifying a pre-agreed upon time and place with the NEP, with services such as Hamilton, Ontario's "The Van" using a mobile number that clients can call or text (The Van 2016). Satellite service refers to the inclusion of community agencies that act as NEPs for the parent NEP, offsetting human resource and space costs while increasing accessibility through a variety of locations and hours of operations. Half the NEPs in Ontario had satellite agreements with local agencies and the parent NEP is responsible for providing supplies and training. Lastly, home visits are used in one-third of NEPs in Ontario and are understood to both increase the accessibility and credibility of the NEP while providing clients the additional comfort of not being in a medical or office setting.

The SCUKs can theoretically be disseminated through the same channels as the sterile syringes, being offered through a variety of social/health agencies that receive funding for the kits, as well as the NEPs already in place (Ivsins et al 2011). Naloxone however needs users to be trained in how to properly utilize the kit in order for it to be effective. The POINT program in Toronto is an example of this, using posters and flyers, word of mouth, media coverage, and its mobile needle exchange van in order to advertise its one on one and group training sessions (Leece 2013). These sessions are twenty minutes long and include symptoms of opioid overdose, contacting emergency services, CPR, administration of the Naloxone, post-overdose care,

storage and handling, disposal, and side effects such as withdrawal (Leece 2013). Additionally, clients had to complete the curriculum and a knowledge assessment before obtaining the prescription (Leece 2013).

Lastly, it is important to take into consideration the social accessibility of these services and how existing stigma surrounding drug use and users may influence harm reduction services. For example, qualitative research on PWUD attending methadone treatment found that when accessing services clients could often feel discomfort and embarrassment as a result of stigma associated with their drug use and treatment, in this case receiving methadone (McPhee, Brown, & Martin 2013). This can lead to discrimination from some staff and medical personnel and may discourage PWUD from accessing services. Furthermore, stigma is associated with mental health issues, incarceration, homelessness, and poverty all of which can affect an individuals ability to access services even when they are available (Tindal, Cook, & Foster 2010). On a macro level, stigma can also indirectly affect service accessibility through its influence on public opinion and thus political systems which are swayed by this opinion (Tindal, Cook, & Foster 2010). This can result in restrictions on funding, the exploration of new harm reduction strategies, and community support for existing harm reduction initiatives.

Accessibility can be understood as the methods through which the service provision described above is distributed and received by PWUD including fixed location, mobile outreach, and in house services that can be contacted through a number of means such as phone or text. Both the resources offered and how they are accessed are foundational concerns in harm reduction strategies, however both public and staff opinion is important in whether services even open and how they specifically operate.

Public and Staff Opinion

The opinions of both the staff providing harm reduction services and the general opinion of the public in which they operate can both have a significant effect on how or if these services are offered in a given community. This section will engage with the concepts of public and staff opinion respectively.

Evidence from the US demonstrates that a divide between scientific, evidence-based findings and public policy can be attributed in part to negative public opinion and thus public opinion could be understood as a barrier to wider service provision (Hobden & Cunningham 2006, Strike et al 2014). Fortunately, public opinion in Ontario supporting harm reduction services and specifically NEPs and SISs has generally increased between 2003 and 2009, with half of Ontarians supporting the implementation of SISs (Strike et al 2014). However, there was also an increase in those opposed, indicating that those who remain undecided or are unaware of harm reduction services are decreasing in number. This suggests that implementation planners must target individuals without a strong opinion on SISs in order to sway their opinion in favour of the sites (Strike et al 2014). Additional research shows that there was confusion among focus groups as to why SISs were necessary when NEPs were already operating, showing a need for further education and public outreach (Strike et al 2014). Lastly, Cruz (2007) provides evidence that higher support for SISs was associated with higher education and middle range income groups, with those in low income groups being the strongest opposed to harm reduction. While public opinion can affect whether a certain service is able to be implemented in a given location, staff opinion can significantly alter how services are operated and accessed and must also be taken into consideration.

Staff opinion is also crucial to understand why services are implemented differently when their general mandate, materials, and even location are very similar. Hobden & Cunningham

(2006) claim that “there is some evidence to suggest that attitudes toward harm reduction among professionals in the addictions field may vary as a function of the specific harm reduction strategy employed and the type of service provided” (p.2). This is demonstrated by Strike et al (2002) which evidences how service provision can be altered depending on how needles are conceptualized — either as objects of risk or preventative tools. Those NEPS that perceived needles to be objects of risk tended to use one-for-one exchange policies, were extremely concerned about their exchange statistics, refused service to those who did not return needles, discouraged secondary exchange (using a friend to pick up supplies), and some monitored individual client exchange practices and tried to push clients towards abstinence (Strike et al 2002). In contrast, those NEPs that perceived them as objects of disease prevention focussed on access and distribution, were willing to provide clients with up to 20 needles per visit, encouraged and facilitated secondary exchange, worked with difficult clients to find solutions, and ultimately believed that too many rules and restrictions will hamper prevention efforts and attendance (Strike et al 2002). This demonstrates a crucial need to understand how staff perceptions regarding harm reduction materials and services are formed, perpetuated, and can be changed to generate positive effects.

This demonstrates a need to be receptive to and document not only the public opinion of harm reduction services, but also to the perspectives and opinions of those who facilitate these services. This can help to overcome barriers to further propagation of these services and effective implementation. In addition to the public and staff however, there is another significant stakeholder regarding opening and operating NEPs and harm reduction services — the police.

Police and State Issues

The effect police and policing has upon the provision of harm reduction services is briefly addressed in the literature, yet offered little analysis beyond merely reporting that there was conflict between police services, PWUDs, and harm reduction services. Interventions and interactions between police and clients are understood to be largely if not entirely negative, affecting PWUD disproportionately with one study claiming that 74.4% of participants had been stopped and searched and 47.8% were kept overnight in a prison, jail, or detention centre (Shaw et al 2015, p.4). Ivsins et al (2011) claims that just under half of the participants in their study of SCUKs reported their crack pipes being confiscated and broken by police, making them nervous about having the paraphernalia with them at all especially since some could not be in possession of a pipe because of bail conditions or a probation order. Strike et al (2002) reported that exchange rates at NEPs were affected negatively by fear that clients would be harassed by law enforcement. Furthermore, if needles are confiscated from clients this will likely severely impact clients engaging with a one-for-one service provider. Leece et al (2013) argue that fear of police involvement may actually inhibit bystanders from using emergency services in overdose situations. Perhaps most striking, half of Shaw et al's (2015) study population had been red zoned by law enforcement meaning that their movement is restricted from particular geographical areas. While Shaw et al (2015) claim that this demonstrates police as "key stakeholders that should be engaged in developing an enabling social environment for harm reduction" (pp.6-7) this stands as an area of study that desperately needs sociological analysis and critical theorization. Overall the literature demonstrates that there is a tense relationship between the police, clients, and harm reduction strategies that needs to be further investigated in order to find ways to work around these issues. These issues need to be circumvented in order the ensure the tangible benefits of harm reduction strategies are able to flourish.

Emotional Labour and Boundaries

As harm reduction work is client oriented and necessitates engaging with people every day, research on emotional and service labour has been collected in order to provide insight to the aspects and challenges that may arise during this work. This includes how emotional labour is defined and why it is significant in relation to service work, how stress resulting from emotional labour is engaged with, and the problematic — and in some cases dangerous — issues that can arise in service work and healthcare positions that could affect clients, especially those in vulnerable circumstances.

As cited by Coulter (2014), the concept of emotional labour was first developed by Arlie Hochschild in 1979 through her analysis of flight attendants and how they used performative emotions in order to be adept at their work. Simply put, emotional labour is "controlled and performed emotions as a regular part of their jobs in order to deliver the best service. Emotional labour refers especially to the visible, performed, outward aspects of the process" (Coulter 2016, p.38). This definition can be applied to numerous areas of employment, both for-profit and non-profit. For retail workers, emotional labour means more than simply fostering a positive relationship, it also means they must adjust their performance in relation to the client's emotions, and be able to remain calm even when faced with anger or insults (Coulter 2014). Furthermore, veterinary staff must maintain professionalism while being faced with suffering and in many cases death, seeming detached and collected while engaging with clients (Coulter 2016). In this way emotional labour can be understood as both engaging in an emotional performance such as in retail or flight attendant work, as well as performing an outward lack of emotions despite what the individual may be feeling authentically. In both cases the purpose is to accommodate the client and deliver the best service possible.

Emotional labour can also be a source of stress with its constant requirement of performativity. Service and care work is often undervalued in society despite it being a key component in the service economy in order to perform jobs well (Pandey & Singh 2016). Burnout — defined as a "degree of physical and psychological fatigue and exhaustion" (p.553) — can be extremely detrimental to workers and often results from not only emotional labour itself, but also in work circumstances with excessive workloads, low resource availability, or both (Pandey & Singh 2016). This stress and burnout is mitigated and managed by workers through a number of strategies. Veterinarians seek to distance themselves personally and mentally from their work, perceiving themselves as simply workers and not emotional beings, or through strategies of escapism by having an active home and social life on which they may focus (Coulter 2016). Debriefing is also noted as a valuable practice in maintaining an emotionally supportive work environment. Debriefing involves the act of staff interacting with each other in order to "acknowledge, discuss, and examine their own feelings" (Peternelj-Taylor & Yonge 2003, p.61). This allows staff to vent their negative emotions, share their experiences, hold each other accountable, contextualize their thoughts on specific issues, and ultimately to grow individually and professionally while mitigating the effects of stress and burnout.

This overview is not meant to imply that all emotional labour is stress inducing and an overall negative experience. Pandey and Singh (2016) note that there are different types of emotional labour that can generate varying experiences. "Surface level" (p.552) emotional work involves covering up one's emotions in order to hide what the worker is genuinely feeling whereas "deep level" (p.552) involvement implies that the individual has altered their emotions to match the expectations of an organization, in a way integrating it into their actual lived identity. While the former may cause stress due to the psychological strain of maintaining an

inauthentic performance, with the latter it has been noted that along with positive emotions involved in the job such as gratitude there can be feelings of personal accomplishment. While certain surface level emotional work may exist alongside deep level surface work (sometimes one may be required to 'put on a mask' even when they identify deeply with their general position), this demonstrates that emotional work can be uplifting as well in some cases.

There are however inevitable risks and dangers within the world of service and emotional work that stem from damaging and inappropriate interpersonal relationships. "Dual relationships" (Reamer 2003, p.122) occur when a service worker in a position of power, such as a nurse or social worker, has a relationship outside of the generally accepted worker-client relationship in such a way that it ultimately rests on the power imbalance between the two and is harmful to the client. This can include but is not limited to personal/sexual relationships, the worker personally or emotionally benefitting from the relationship while being detrimental to the client, and inappropriate or expensive gift giving (Reamer 2003). Essentially this creates a conflict of interest in which the worker can pressure or have power over the client in a manner that may or may not benefit the worker but always harms the client in some capacity. These dual-relationships are defined as "boundary violations" (p.56) but should be differentiated from "boundary crossings" (p.56) which can prove to be pivotal in effectively performing service and care work. Boundary crossings can be considered small deviations from traditional practice and are often beneficial to the client. These can include last-minute appointment changes, small gifts and resources outside of normal parameters, and brief disclosure of personal information for the purpose of building strong professional relationships and trust with the client. It is therefore important to note that while professionalism and appropriate boundaries must be observed, there

is a grey area in which workers must operate in order to effectively carry out their labour to the best of their ability.

Benefits and Challenges of Harm Reduction

The general benefits of harm reduction have already been outlined in the above sections as prevention of overdose, disease transmission, and other harms associated with drug consumption. There are a number of additional effects however — harm reduction strategies are associated with reductions in drug use and crime, increased rates of employment, and improved interpersonal relationships (Hobden & Cunningham 2006). They improve public order by reducing public drug use, disturbances, litter, and gives respite from the street environment and increases contact between PWID and health and social services (Strike et al 2014). While an NEP with a modest staffing can prevent 24 HIV infections over five years and provide cost savings of over 1.3 million, Insite alone has had a 35% reduction in the rate of fatal overdoses in the surrounding area after only two years of operation (Strike et al 2002b, Shaw et al 2015). Ivsins et al (2011) had participants stating that the accessibility of pipes meant that they did not have to use makeshift or broken items and thus have reduced chances of injury and were able to save money from not buying new supplies. Additionally, they claim that this reduced the amount of arguments and physical violence that erupted over a scarcity of materials. Because of the dynamic and evolving nature of harm reduction practices, benefits such as these need to be accounted for and investigated in order to perpetuate and expand the positive social effect they entail.

This section aims to demonstrate the main benefits of harm reduction services including reducing the spread of disease, preventing injury, economic relief, reduced crime rates, and

preventing deaths from overdose. While these benefits are significant in terms of research, so are the corresponding barriers to such benefits.

Just as important as understanding the benefits of harm reduction and how to develop them, challenges need to be overcome, eliminated, and prevented. One barrier, touched upon above, is public and staff opinion. Public opinion and stakeholders who believe that harm reduction services promote drug use and encourage crime can be a major obstacle in feasibility studies (Strike et al 2014). Resistance from healthcare professionals, lack of perceived need, anticipated community resistance, lack of resources, and lack of staff can all be barrier to effective service provision and basic implementation of these services (Hobden et al 2006). Regarding Naloxone programs, the capacity to offer training was cited as a challenge for program implementation, as well as exclusion of the drug from the Ontario Drug Benefit formula (Leece et al 2013). The first barrier may be overcome by enabling non-nurse harm reduction counselors to perform training, and training could be easier if the drug was given in the form of intranasal atomizers or auto-injectors (Leece et al 2013). At Insite, nurses are not permitted to assist a client with injections directly, and thus can increase risk in those who need physical assistance because of inexperience or disability (Shaw et al 2015). There are multiple challenges related to accessibility of services, as well as state/police intervention that have been reviewed above. This section is not exhaustive, but offers a brief look at the multiple barriers and solutions that deserve academic attention in order to further understand how they operate and are overcome.

Conclusion

This chapter has provided a summary of works within the past two decades that are pertinent to themes related to harm reduction, needle exchanges, and the workers who operate

them. While much of this work relates to policy, provision of harm reduction services, and the materials distributed, there is little research that has been performed that engages with harm reduction workers themselves. Furthermore, this research has been focused either on SISs and their many benefits and materials, or is quantitative in nature, dealing with disease prevention statistics and cost-benefit ratios of harm reduction programs in order to evidence their efficacy. Therefore, there is a need for qualitative research on harm reduction workers themselves in order to fill this gap in the literature and indicate other areas that may need to be investigated. A methodology, method, and form of data analysis suited for such a project is thus also required, which is discussed in the following chapter.

Chapter 3 - Methodology, Methods, and Data Analysis

This research is aimed to explore the experiences, perspectives, and values of harm reduction workers within the Niagara Region. The project elucidates their responses in relation to the themes presented in the literature review including the service they provide, accessibility within the site, public opinion as well as their own perspectives, police and state issues, and lastly the benefits and barriers of their work.

This chapter reviews the theoretical approach used for this project, in addition to the methodologies and the epistemic understandings, advantages, and methods they contribute to the research performed. Furthermore, the advantages and disadvantages of semi-structured, face-to-face interviews will be overviewed as well as the importance of power relations, social locations, and ethical considerations, the understanding of which is integral to this methodology. Lastly, also included are details about the recruitment process, sample selection, and the specific methods of the interview itself.

Theoretical Approach – Political Economy of Health

This research used a political economy of health approach in order to better understand and contextualize the findings generated throughout the project. This section will define political economy of health and outline some of its facets to demonstrate its relevance to this study. Outside of human health and illness, political economy focuses on how economic and political systems function to create public policy that is the basis for the inequitable distribution of resources (Raphael 2017). Often, this involves a critique of capitalism or the dominance of the market as an institution with the general tendency for wealth to be a determinant of political power. Thus, the corporate and business sectors overwhelmingly influence public policy,

especially that surrounding healthcare and industry, far more than those who will be negatively impacted by such policies (Raphael 2017, Nowatzski 2012).

Political economy as an approach is linked to health through the social determinants of health, a concept which posits that human health and illness is strongly affected by social position – a position determined by differences in the amount of resources one has at their disposal, their education level, gender, race, sexuality and so forth (Coburn 2009). Furthermore, not only is human health affected but healthcare systems themselves can be understood as socially and politically determined given the influence that public policy has on such systems, and the multiple stakeholders who in turn construct public policy (Coburn 2009). This public policy could be crafted, for example, in relation to pharmaceutical accessibility, the ability for nurses or doctors to unionize, or which procedures are considered medically necessary and which are not for insurance purposes. The political economy of health approach therefore critically engages with political and economic structures in order to demonstrate how they affect healthcare, human health, and the relative differences between people of varying social positions.

Concerning political and economic structures, the neoliberal state is of particular interest as it is the current manifestation of capitalism in North America and much of the Western world, primarily originating from Thatcher's and Reagan's administrations (Coburn 2009). In *A Brief History of Neoliberalism*, David Harvey (2007) claims that:

> The neoliberal state should favour strong individual property rights, the rule of law, and the institutions of freely functioning markets and free trade… Neoliberals are particularly assiduous in seeking the privatization of assets… Internally, the neoliberal state is necessarily hostile to all forms of social solidarity that put restraints on capital accumulation… The coercive arm of the state is augmented to protect corporate interests and, if necessary, to repress dissent" (pp.64-65,75, 77).

Here we see that the neoliberal state is one dedicated to propagating and enforcing the free flow of capital and private property rights, through violence if necessary, and at great social cost. In terms of healthcare, this means that systems are developed not necessarily for the welfare of general society and the common good but rather for being profitable and providing a return on investment. Privatization of healthcare is of pivotal concern to neoliberal interests in order to fully exploit healthcare systems as a product to be sold, rather than a public good to be provided to everyone regardless of social position and socio-economic status. Furthermore, neoliberal and corporate interests will also use their power and capital to secure representation as stakeholders in the process of crafting public policy, such as healthcare provision. However, they are only concerned with providing a return to their shareholders as opposed to the benefit provided to consumers that may use these services.

On a more micro-scale, the neoliberal model also envisions an ideal type of citizen which exists within its framework, a neoliberal individual which differs from citizen types of the past. Through a discourse of economization of both the state and social institutions, the previous citizen or civil servant is reimagined as a consumer or entrepreneur for example (Pyysianinen, Halpin, & Guilfoyle 2017). Alongside this reimagining is the idea that this new neoliberal individual is always a rational actor, enterprising, and responsible for their own wellbeing and interests. This "responsibilization" as a discourse is central to the logic of neoliberalism in that:

> Neoliberalism is a political rationality that tries to render the social domain economic and to link a reduction in (welfare) state services and security systems to the increasing call for "personal responsibility" and "self-care". It is a form of governing – at least as an ideal type – which seeks to reshape sensemaking, even subjectivity, of individuals in such a manner as to shift their explanations for problems or concerns from external agents or forced to the self (Pyysianinen, Halpin, & Guilfoyle 2017).

In terms of health and healthcare this means that individuals are largely expected to be responsible for their own health choices and outcomes and it is through their action and inaction that their health will be stable or in decline. Insofar as some health issues may be out of an individual's control such as hereditary disease, that citizen is expected to be responsible for financing the cost of their treatment and medical assistance; this is done either through their income or by paying into insurance schemes to cover such a scenario. As the political economy of health demonstrates, this neoliberal perception of health as based on personal choice is in direct contradiction to the social determinants of health model that states that health inequalities rather are largely the result of unequal distribution of resources, social location, and political factors which remain outside the control of most people.

Since the economic model of neoliberalism affects healthcare in that it is marketed to those who can pay for it rather than society in general, health inequities result due to an imbalance of power and stratified structural relations (Ashcroft 2010). Despite having a single-payer nationalized healthcare service, Canada is no exception to neoliberal influence and restructuring in several sectors including healthcare. Pharmaceuticals, dentistry, eyewear, and other aspects of healthcare are still commodified and privatized for the purpose of profit and are thus only available to those with the means to afford them. While Canada does have nationalized healthcare, this is only because of significant public support which has prevented the government from commodifying parts of the system and succumbing to the constant pressure of the market (Coburn 2009). Despite this, healthcare will continue to be a site of political struggle as social institutions are constantly contested and struggling against privatization. Even among Organization for Economic Co-operation and Development (OECD) countries Canada ranks

poorly in respect to infant mortality, an indicator of the quality of healthcare in a country (Coburn 2009). Overall, Canada must be understood as a neoliberal state whose healthcare system is threatened by market forces which seek to privatize it in full at the expense of the general population, who are also being reimagined as neoliberal individuals who are and should be responsible for their own health and wellbeing as opposed to the state or community.

Proponents of the political economy of health approach have put forward both critiques of this neoliberal system and ways it can be resisted or ameliorated. Coburn (2009) suggests that class struggles are one of the main determinants of the extent of socio-economic inequalities which shape health and healthcare; thus political organization and action on a class basis are crucial in resisting neoliberal restructuring and in consequence further health inequalities. Furthermore, he supports collective and state institutions of healthcare as opposed to economic growth alone as a way of ensuring quality population health, stating that "well functioning and governed societies are as much a determinant of economic growth as economic growth is in producing improvements in human well being" (p.42). Raphael (2017) claims that research as opposed to market interests must be used to craft public policy regarding healthcare in a way that will benefit the public which such policy concerns, relying on evidence in order to make sound decisions. Mooney (2012) calls for strong democratic institutions which use the communities affected by policies as consultants rather than consumers when making decisions regarding their healthcare, as the community has "credible commitment" (p.395) – an interest in the long-term results of decisions as opposed to short-term interest in generating profits. Lastly, Bambra (2009) claims that a more recommodified social democratic welfare state would be preferable to a neoliberal market driven state in relation to public health, as evidenced by infant mortality rates.

In summation, political economy of health is an approach which notes that politics, the economy, and health are all connected through healthcare and that social services such as healthcare cannot be viewed in a politically neutral way. In this project, as harm reduction services are understood as a proponent of healthcare and disease prevention, the political economy of health approach will be used to help determine to what extent the NEP itself and the workers act as an extension of neoliberal policies and economics, or, in contrast, how it operates as a site of resistance. Since political economy of health is both concerned with individual social position and its effects of health, and is critical of socio-economic systems which propagate health inequalities, a blend of methodologies has been utilized in the design of this study.

Interpretive and Critical Methodology

This research progressed using both interpretive and critical methodologies in order to take advantages of their strengths and minimize their weaknesses. Interpretive methodology, rooted in symbolic interactionism, is focused on "meaning-making" (Schwartz-Shea & Yanow 2012, p.46) of social actors and how they make sense of certain concepts, events, people, institutions, and other phenomena (Esterberg 2002). This methodology understands that reality is a social construction and thus the focus turns to how people interact and relate with these social constructions, and how their differing subjectivities generate different lived experiences and knowledge. This applies to the research process as well, since researchers as subjective humans generate meaning with their participants through how research is directed, questions are crafted, and how answers to such questions are interpreted, negotiated, and presented in a final research product (Schwartz-Shea & Yanow 2012).

Interpretive methodology is advantageous to this project for two reasons. The first is that it "privileges local, situated knowledge" (p.5) and participants are understood as having agency,

not simply being subjects from which data may be extracted and presented objectively. They are not cogs in a machine to be examined and noted but rather are influencing and in turn being influenced by the social entities, environments, and contexts in which they reside. In this way interpretive methodology acknowledges the research participants as expert knowers of their own worlds in which they operate, and can offer insight beyond what an 'outsider' may be able to. This allows the researcher to generate knowledge and data that is empirical and embodies the sort of "exposure" (p.85) that interpretive research aims to achieve. This is in contrast with a positivist framework that not only sees the world as purely objective, but also strives for generalizability and falsifiability, concepts that are ill-suited for an interpretive, contextual methodological framework.

This methodological flexibility is the second advantage of an interpretive model, in that it allows research to operate outside of the rigid positivist framework that demands evidence that can be tested, validated, and repeated in order to ensure its value. This epistemic perspective calls for questions that are designed in order to maximize exposure, "the notion that the researcher wants to encounter, or be exposed to, the wide variety of meanings made by research-relevant participants of their experiences" (p.85) as opposed to using them as the operationalization of a variable. Furthermore, as only one research site is being included in this study, the goals of interpretive research — to generate data that is reflexive, transparent, and contextual — is more appropriate than the generalizability and replicability sought after by a positivist framework. Lastly, it allows research design, direction, and questions to be changed as necessary to accommodate better investigation, rather than a complete overhaul in the case of ineffective research tools/questions such as in a positivist-qualitative framework. Interpretive research however has been subject to critiques that claim it is "too preoccupied with individual

meaning-making, at the expense of a consideration of more institutional phenomena, including power" (p.43). Within this context, the application of a critical methodology can be advantageous, especially for a project such as this which deals closely with marginalized populations and the people who engage with them daily.

In contrast to the somewhat individualizing (yet still relational) focus of interpretive methodology, critical methodology takes into consideration both the ways in which systems of oppression and inequality marginalize certain segments of the population and how researching these peoples and systems can work towards a form of emancipation (Esterberg 2002, p.17). This perspective ties in with interpretive methodology in that "they want to understand not only people's subjective feelings and experience but also the material world and power relations within it" (p.17). This methodology is important in order to reveal oppressive conditions and to denaturalize and deconstruct them so that they may be made apparent and thus resisted, as opposed to being maintained and reproduced. A critical approach is useful to effectively analyse systems that may affect the research participants and their clients — gentrification, policing, lack of resources, legal barriers — all of which may be said to be based in social constructions of capitalist property relations. However, all still have a very real material effect on those who have to operate in such contexts. This influence, of course, in turn affects their meaning-making processes but may be overlooked if focusing on meaning-making alone.

While it may be argued that the ontological understandings of these two methodologies are in conflict — the former focusing on subjectivities and meaning whereas the later is concerned with material inequality — I would argue that they can be used to support and strengthen each other. It has been demonstrated that subjective understandings and meaning making can have a material effect on service accessibility and operation (Strike et al, 2002), and

alternately inequalities and very real marginalization produce different subjectivities — both methodologies are concerned with the relational aspect of human experience. In this, interpretive methodologies aid in understanding the different meanings and values of the participants researched — how they are formed, influenced, and why they differ — while a critical methodology highlights the material and relational basis that generates these meanings, such as differing values between harm reduction workers and the police for example based on their objectives, histories, and perspectives. More simply put, interpretive methodology is useful to understand subjectivities beyond variables and generalizations while critical methodology aids in understanding the material conditions that influence these subjectivities. In order to apply both methodologies a quantitative approach would be limited to the latter, and thus semi-structured interviews have been utilized instead in order to gain an understanding of participants subjectivities and their material implications.

Semi-Structured Interviews

The primary method of data collection in this project consisted of semi-structured interviews. These interviews are more appropriate for investigating the experiences and subjectivities of harm reduction workers than closed-ended structured interviews because they allow the topics to be explored more openly and for workers to express what is important to them in relation to the questions being asked (Esterberg 2001). Furthermore, they can give responses in their own words and are not restricted to a predetermined set of answers as in a survey or interview with closed ended questions. Alternatively, the use of semi-structured interviews as opposed to open interviews allows the use of a research guide to keep interviews focused on the topic being investigated. This allows for multiple participants to be sampled and interviewed while keeping the overall time and labour needed for recording and note taking, transcribing, and

analysis manageable and within project limitations.

Semi-structured interviews have multiple advantages. They avoid some of the ethical dilemmas within the power relationship between researcher and subject that is present in closed ended interviews and surveys (Harrison & Callan 2013). This allows for the co-construction of data as participants can take the conversation in any direction they choose as long as it is still related to the subject being investigated. This opens new avenues of inquiry that may not have been readily apparent to the researcher at the onset of data collection (Esterberg 2001). Lastly, interviews, especially semi-structured and open interviews, are best for investigating the subjective meanings, perspectives, and lived experiences of research participants.

These interviews are not without flaws however. Positivist researchers raise concerns about validity and reliability stemming from small sample sizes and biases that may affect research during the interviewing and analysis stages (Neuman & Robson 2011). In addition to being both cost and labour intensive, interview transcripts and other data may not be available to peers for independent verifications due to confidentiality issues, as is the case in this project. Lastly, interviewing methods, especially with small sample sizes and geographies in which they are being deployed, come with their own set of ethical issues and concerns which will be discussed in the following section.

Power Relations, Social Location, and Ethical Considerations

In qualitative research (and perhaps in all research), it is critical to be reflective of one's social location, or how one relates to the topics, participants, questions, and methods being used. Luker (2008) claims that performing "good research" involves understanding the socially situated nature of research itself, being reflexive of how the research process is fraught with power relations, ethical considerations, and outside influences. This reflexivity is defined by

Schwartz-Shea and Yanow (2011) as "consideration of how the researcher's own characteristics matter and, where feasible, assessments of the ways in which his particular scholarly community and even the wider social milieu impact the research endeavor" (p. 100). I sought to pursue this consideration through the use of Doucet's (2007) concept that reflexivity can be understood as "three gossamer walls" (p.73), each a metaphor for "theorizing diverse sets of reflexive relationships that occur throughout the process of conducting, writing, and reflective back on one's research… the thin and tenuous lines that exist in research relationships" (p.74). The first is between the researcher and themselves, the second between them and research participants, and the third with the audience that ultimately receives and uses the research.

The first gossamer wall is that between the researcher and themselves, not only their inherent social position denoted by race, gender, and other factors but with their past and present selves, the academic communities to which they belong and have been formed within, and their personal/political reasons for pursuing a topic. Doucet (2007) urges the researcher to delve into the "relationship between our projects and our *selves*… to reflect on and dissect the personal or political *motivations* that matter in how we come to our research topics" (p.75). My interest was piqued regarding the topic of harm reduction when I first learned of Safer Crack Use Kits in the second year of my undergraduate degree. It seemed surreal at first that such paraphernalia would be deployed as an instrument of public health. I had lost friendships to addiction and knew of people who had physically lost friends and family themselves and continue to. Furthermore, my academic concentration in criminology endowed me with a critical perspective of the current method of controlling drug use largely through the criminal justice system, and so harm reduction methods seemed a refreshing breath of rationality in a social milieu that was individualizing and sought to criminalize rather than support. These experiences are some of the

formative reasons I sought to engage with the topic of harm reduction and the people who facilitate it.

The second gossamer wall involves the researcher and the researched. In this I include not only Doucet's (2007) original meaning in how the researcher relates to their participants both literally and textually, but also the ethical considerations that needed to be comprehended before the project began. As a volunteer at the research site for over three years, I have relationships with the research participants as co-workers, and many as friends. As opposed to traditional positivist frameworks in which this prior association may be seen as problematic for its eschewing of objectivity, the interpretive framework involves an understanding that these connections can be crucial in the development and conduct of research (Schwartz-Shea & Yanow 2011, p. 26). In this instance, not only did my experience allow me to gain background knowledge of the subject matter being researched — harm reduction theory, terms used, and general operation of the agency — but also aided me in obtaining access to the workers for the purpose of this research. In this case, the term access is used to mean both access to the agency itself with the permission of the Executive Director and to the workers on a personal level. Almost all the participants I had requested an interview from had agreed to participate, something that may have been difficult otherwise, and no doubt a previous relationship allows participants to be more comfortable and divulge information and narratives that may not have been shared with an outside researcher who was unfamiliar with the community and its individuals. However, it may have also been the case that certain information was not shared because of this closeness to participants, as they may not want to disparage their self-image in the eyes of a friend or volunteer.

Beyond being a volunteer and a co-worker however, the social location of the researcher

in comparison to the researched involves a power relationship that must be acknowledged. The researcher chooses the general topic, formulates the questions, and codes the data in such a way that they influence the ultimate product of the project. Within this power structure, and with hopes of disrupting it, I had tried to formulate the questions in a way that allows the participants to delve into what is important to them, and was sure to ask them if there was anything they thought was missed or should have been asked. Furthermore, ethical considerations had been taken in order to protect research subjects, especially since the execution of harm reduction strategies often involves vulnerable populations and confidentiality.

While the initial Research Ethics Board clearance had been obtained for this project, "ethics board approval is not the same as engaging with ethical issues… in interpretive social science, ethical concerns are not a separate subject, but instead emerge throughout the project" (Schwartz-Shea & Yanow 2011, p.22). Throughout the project there had been multiple ethical checks on the process in order to safeguard the participants, including the ability to withdraw from the study at anytime, to omit sections from their interview for whatever reason in order to protect their wellbeing, and the protection of their identity through the use of assigned pseudonyms rather than given names. Furthermore, they each had the chance to review their transcripts to identify lines or sections that may be of issue and need to be omitted, and are also presented with any quotes to be used directly in this paper. These safeguards are especially crucial in this project because the research takes place in a single location and the number of participants are relatively small, with all of them working with vulnerable, largely confidential populations.

Lastly, the third gossamer wall is that between the researcher, their research, and the audience itself. This refers not only to the epistemic and theoretical communities that influence

the researcher but also how a particular piece of research will be received, read, and applied (Doucet 2007). In the case of this project, the sociological and academic communities present at Brock University, as well as the theoretical viewpoint of harm reduction itself have influenced the work. This is apparent in the qualitative nature of this work, and the focus on narratives from people on the ground who are involved with the subject matter at hand, as opposed to influential experts or claims deduced from bodies of numerical data. In terms of who this piece is written for and may be read by, the most obvious first consideration is that it will be read by a thesis defence committee for the purposes of this program. Beyond that it could be read by anyone, such as the workers themselves, clients, managers, other needle exchanges, academics, interest groups, and many other audiences. My hope is to make the piece as accessible as possible in the interest of disrupting the privileging of knowledge to academics, and ultimately wish that it is used to further research on this rich and complex topic.

Recruitment, Sample Selection, and Methods

As a qualitative research endeavour this project followed textbook designs in matters of sampling, recruitment, and methods. This section describes those aspects of the design as well as their associated factors.

This project used purposive sampling in order to reach as many workers as possible at a single site - that being the ASO. This is appropriate as individuals in this setting are most easily reached through email or directly through their office, and the research site itself has only a small number of employees (less than fifteen). This site was chosen because it offered services not only to the city in which it is located, St. Catharines, but also to the surrounding Niagara region, thus covering a large area from a central hub with the assistance of satellite sites. The concept of sequential/theoretical sampling was also deployed, and interviewing ended once certain themes

and data had begun to be repeated and little new information was added (Neuman & Robson 2011). These sampling methods were chosen to achieve "exposure" (Schwartz-Shea & Yanow 2011, p.87) discussed above, rather than the ability to generalize claims from sample to population. This means that an attempt has been made to capture a large swath of meanings generated by participants, understanding "that occupants of various positions within a research setting might be expected to have different views on the subject under study" (p.85). Saturation was achieved not only theoretically, but numerically as well, as by the time sampling was nearing completion the majority of employees had responded, participated in the research study, and given interviews. In total, there were ten (n=10) interviews performed, three with support staff, six with needle exchange staff, and one with a public health nurse. Their experience in the field of harm reduction ranged from 1 to 16 years of experience in the agency with an average of 7.5 years. Support staff work for the ASO providing support services for clients living with HIV/AIDS as opposed to directly being involved in the NEP although there is a significant crossover between their clients and that of the NEP and thus have been included as well. Furthermore, they consider themselves harm reduction workers and an integral part to the operations of the ASO.

The physical recruiting was done through personal visits to the office where I could present the letter of invitation and answer any immediate questions the participants had about the project. If they expressed interest in participation their email was recorded and an electronic copy of the consent form was e-mailed to them for review before the interview was performed and the document needed to be signed. Compensation was offered in the form of $20 Tim Hortons gift cards that were available to the interviewee at the beginning of the interview, in case they decided to end the session before it finished. Clearance was given for this recruitment from

the Executive Director of the agency although participation was not disclosed to this individual in the interest of protecting participant confidentiality. Interviews were scheduled to take approximately one hour with the average interview being 50 minutes. Interviews were recorded using two electronic devices, and later transcribed into electronic documents for the purpose of data analysis. These transcripts were then sent to participants in order to be checked for errors and portions that compromise confidentiality in order to make adjustments before the data analysis procedure was employed.

Data Analysis

In the interest of rendering the data analysis process as transparent as possible, it is necessary to make explicit the steps followed to undertake such an endeavour for the reader to properly evaluate the quality of a study and the validity of its findings. Indeed, Green *et al* (2007) states that "it is surprising how often details about the process of analysing qualitative data are missing from the reporting of studies… studies are presented as though data analysis is self-explanatory, common knowledge, or even intuitive" (p.546). Furthermore, Green *et al* (2007) claim that many studies simply state that they used a computer program or say they located themes and categories rather than actually indulging the reader in the process applied to the data (Green et al, 2007). Therefore, this chapter will highlight the data analysis process utilized in this study, reviewing each step of the coding with both text and images in order to illustrate how the resulting categories were formed, organized, and finalized.

Neuman and Robson (2011) will be used as a general guide to the steps of data analysis, and their process will organize the subsections of this chapter — open coding, axial coding, and selective coding, as recommended by Strauss and Corbin (1990); a brief subsection outlining

limitations will also be included. While a computer program was not included as part of this project because of time and resource constraints as well as personal preference of the researcher, the word processor Google Docs acted as the main tool by which the data was organized and reviewed. Data analysis, however, began long before the formal process of coding does, with preliminary and *a priori* themes and categories emerging through immersion in the data.

Open Coding

The first step of data analysis — immersion in the data — involves repeatedly engaging with the data through text or audio-visual format in order to form rudimentary conceptualizations of the data (Green et al 2007). In this study this process began during the very transcribing of the interviews themselves, having taken concise notes in order to better identify pertinent information from the data to be later coded and organized. My shared role as both the interviewer and the individual performing data analysis is also advantageous in that it allows for a thorough and contextualized understanding of what is being expressed in the data. This is opposed to having a research team in which the interviewer and the analysis team/individual are separate people and the risk of misinterpretation of notes and thought processes may occur. Through this immersion emerged some of the preliminary categories used to identify significant information, such as “frustration with policies”, “migrant worker issues”, and “professional boundaries” — all concepts that may not have been apparent with only a basic knowledge of this project’s focus and purpose of investigation.

Once the researcher has identified the first inklings of themes and concepts worthy of exploration through this process of immersion, the first stage of data analysis, open coding, can begin. The understanding within academia is that coding itself is the process by which large amounts of qualitative data are reduced into a format that can be organized, explained, and

eventually used to evidence claims in relation to a general research question (Neuman & Robson 2011). Blair (2016) explains that "qualitative data analysis involves two phases: decontextualization and recontextualization," (p.93) in which open coding is the initial decontextualization. Codes are abstracted from the actual interview transcript itself in order to create segments of data that are later recontextualized in a final findings section in which significant quotes from interviews are used to illustrate concepts, categories, and themes that emerge from the coding process.

More practically, this decontextualization/open coding is performed traditionally by making notes in the margins of interview transcripts and highlighting or underlining the phrase, line, or word that the code corresponds with. While some analysts will use a specific unit of measurement such as only words, or line by line, Chenail (2012) notes that what is most important, rather than arbitrarily choosing a unit of measurement and adhering to it dogmatically, is to "focus on portions of data that have potential as meaningful undivided units to analyse, it is fine to read a transcript line-by-line… [but] you might be better served to focus on units shorter or longer than an arbitrary line of text" (p.266). Coded text for this project tended to range from a few words to entire paragraphs, with some codes overlapping with others when necessary to avoid overlooking important details. Additionally, instead of writing in margins Google Docs was used as noted above in order to use the "insert comment" function as a way of highlighting the specific phrases under scrutiny as well as writing in the margins. This is useful for a number of reasons as it is easy to find lines of text using the search document function, one can transfer transcripts electronically, codes can quickly be copied and pasted to other organizing documents, and uses less paper thus reducing costs. Furthermore, using this method of open coding tracks changes and change history that allows for an audit trail to be constructed so the researcher can

account for units of measurement and note any significant developments throughout the process (Chenail 2012). When a section of coding is finished, it typically looks like the document as pictured in Figure 2:

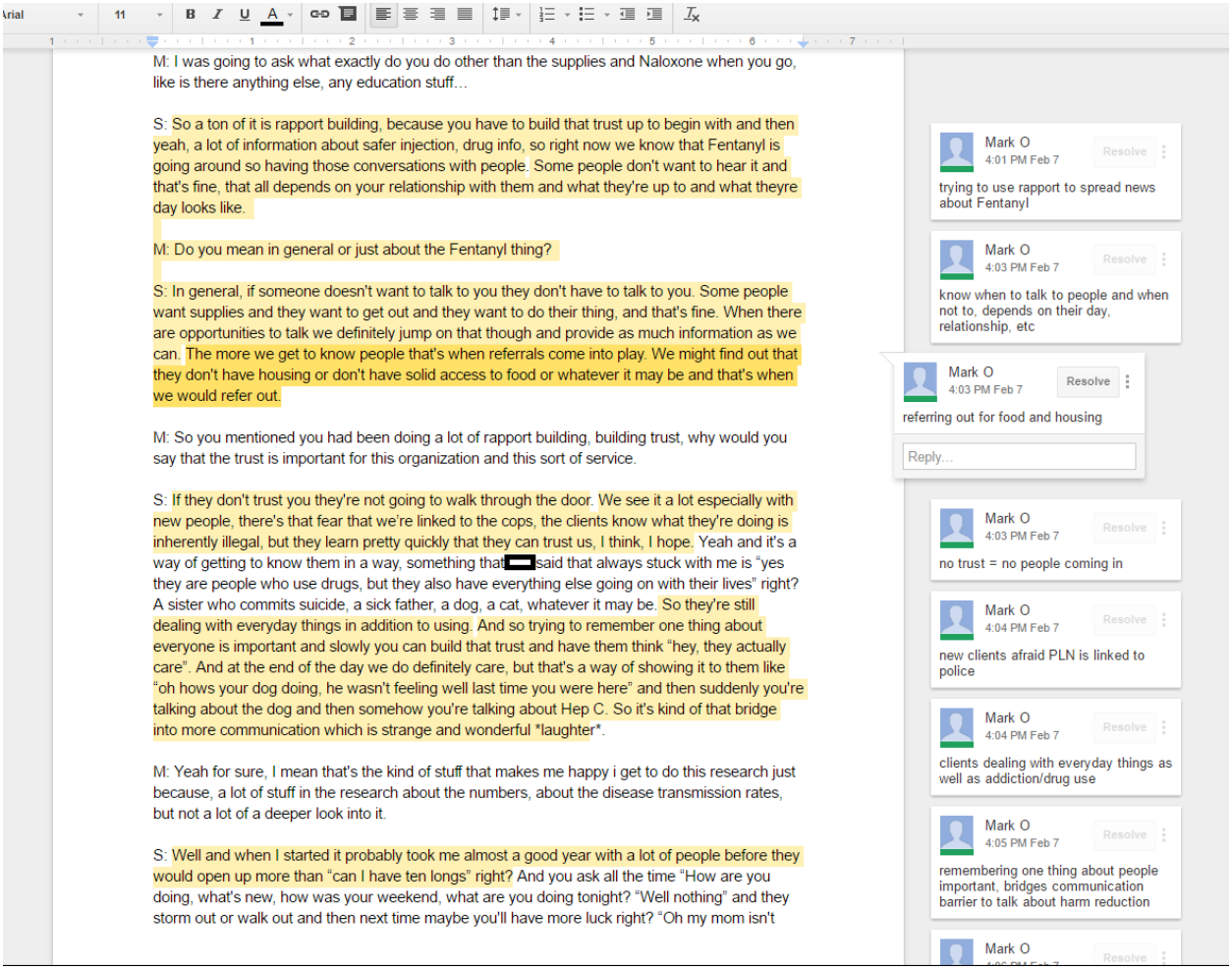


Figure 2 - Open Coding Document

Axial Coding

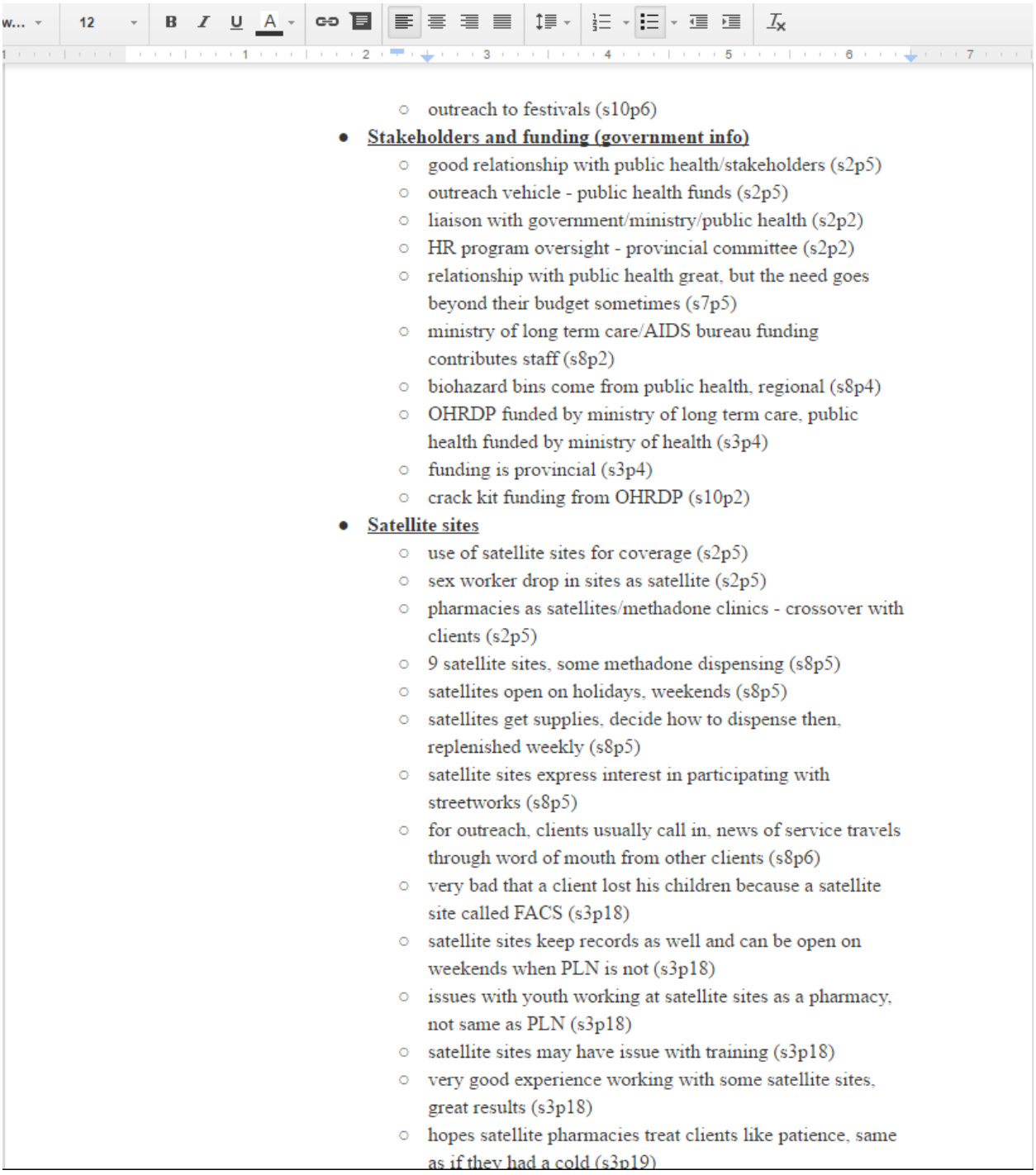
The second phase of data analysis — axial coding — involves the researcher taking the codes formulated in open coding and beginning to sort them into organized themes and categories that are pertinent to the research question and significant to the interviewees themselves (Neuman & Robson 2011). In this way, the preliminary themes emerge through axial

coding in two ways: the first being *a priori* themes that "come from the characteristics of a phenomenon being studied; from already agreed on professional definitions found in literature reviews… in fact, the first pass at generating themes often comes from the questions in an interview protocol" (Ryan & Bernard 2014, p.88); and the second being induced from the data itself. An example of the former would be "relations with police", given this was a specific phrase used in a question one could reasonably assume that this would be a theme to emerge from the interviews, whereas an example of the latter could be "the opiate crisis in Niagara" which was not asked about directly but emerged nonetheless.

The data gathered through this project varied and interviews did not always follow the set guide that was formulated beforehand, therefore a thematic method of analysis was used to process the data during axial coding. These themes are understood as conceptual categories that encapsulate significant aspects of workers' experiences within the needle exchange and engaging with their organization and clients. As put by Bernard (2014), themes are the conceptual labels applied to "discrete happenings" and "expressions", better understood as the actual line-by-line data itself (p.87). The term "theme" is hotly contested however; whereas Bernard (2014) understands themes as categories that organize expressions, Green *et al* (2007) maintain that themes specifically go beyond the description of expressions and provide some sort of interpretation of the issue being researched, to be ultimately generalizable to other populations and geographies. By this standard, the "themes" investigated in this study perhaps fall better under their understanding of "categories" – conceptual labels that categorize expressions and are identify a connection between codes that share a relationship. As a result of the small sample size of this project and the singular location investigated, this research makes no claim of generalizability but rather seeks to "make a modest knowledge claim with appropriately limited

conclusions… identifying useful research directions to advance knowledge in this field" (Green et al 2007, pp.548-549), as Green *et al* (2007) sets out as the goal for this type of research involving categories. Beyond semantics, this research understands the themes investigated as those that are pertinent and significant to the research participants in relation to both the research questions and their lived experience.

Performance of this phase of coding was also undertaken using electronic documents, including a computer set-up with the original interview transcript with open codes on one half of the screen and another document containing the constructed categories and organized codes in the other. While proceeding through the interviews and open codes, directly copied codes were inserted from the interviews into the second document in order to methodically process them for final review. This process is similar to the "cutting and sorting" (p.94) method outlined by Ryan & Bernard (2014) that includes putting codes on index cards and then sorting them into thematic piles, only performed electronically. The general product resulted in an arrangement of data sorted by category, each with an assigned code for later review during the final stage of data analysis as seen in Figure 2:



- outreach to festivals (s10p6)

- **Stakeholders and funding (government info)**
  - good relationship with public health/stakeholders (s2p5)
  - outreach vehicle - public health funds (s2p5)
  - liaison with government/ministry/public health (s2p2)
  - HR program oversight - provincial committee (s2p2)
  - relationship with public health great, but the need goes beyond their budget sometimes (s7p5)
  - ministry of long term care/AIDS bureau funding contributes staff (s8p2)
  - biohazard bins come from public health, regional (s8p4)
  - OHRDP funded by ministry of long term care, public health funded by ministry of health (s3p4)
  - funding is provincial (s3p4)
  - crack kit funding from OHRDP (s10p2)
- **Satellite sites**
  - use of satellite sites for coverage (s2p5)
  - sex worker drop in sites as satellite (s2p5)
  - pharmacies as satellites/methadone clinics - crossover with clients (s2p5)
  - 9 satellite sites, some methadone dispensing (s8p5)
  - satellites open on holidays, weekends (s8p5)
  - satellites get supplies, decide how to dispense then, replenished weekly (s8p5)
  - satellite sites express interest in participating with streetworks (s8p5)
  - for outreach, clients usually call in, news of service travels through word of mouth from other clients (s8p6)
  - very bad that a client lost his children because a satellite site called FACS (s3p18)
  - satellite sites keep records as well and can be open on weekends when PLN is not (s3p18)
  - issues with youth working at satellite sites as a pharmacy, not same as PLN (s3p18)
  - satellite sites may have issue with training (s3p18)
  - very good experience working with some satellite sites, great results (s3p18)
  - hopes satellite pharmacies treat clients like patience, same as if they had a cold (s3p19)

Figure 3 - Axial Coding Document

The final document included hundreds of codes and spanned thirty-three single spaced Google Docs pages in total when completed. Once the codes were arranged, the document was ready to

be reviewed and the categories finalized for the third stage of data analysis — selective coding.

Selective Coding and Finalization

Selective coding is the final round of data analysis and is centred around reviewing the codes, thematic categories, and general organization of the axial coding document to ensure appropriate placement of all data to express significant meaning. Neuman and Robson (2011) describe the process as "scanning data and previous codes and determining a core category around which the remaining categories all "fit"" (p.335). Certain categories were merged or removed if there were too few coded data to support their construction, whereas larger "general" categories were reduced as much as possible by re-organizing their constituent data into existing categories or by creating new ones where necessary. To fully illustrate how this final step affected the data process, one can compare the preliminary *a priori* and emergent categories that the axial coding document began with and the later finalized categories in the resulting selective coding document. Inserted below are the former axial coding themes:

- **Harm Reduction Practices in the Niagara Region**
    - Political Climate
    - Public Awareness
    - Services
    - Dual Agency
    - Nursing care
    - Case work
    - Inclusivity
    - Migrant Workers
    - Relationship with Police
    - Recruitment
        - Volunteers and clients
- **The Experience of Harm Reduction Workers**
    - Emotional Stress
        - Debriefing
        - Solidarity
        - Humour
        - Frustration

        - Client deaths
        - Client trust
    - Feelings about/ experiences with clients
        - Client Variability/description
            - Support - two types of clients
        - Love for clients
        - Professional boundaries
        - Client experiences
        - Importance of trust

For comparison, the later finalized themes are as follows:

- **<u>Harm Reduction Practices in the Niagara Region</u>**
    - **Niagara Region**
        - Political Climate
        - Public opinion of PLN/SW/Service
        - History/change over time
        - Opiate Crisis
    - **Dual Agency and Services**
        - the NEP
            - General
            - Staffing/Administration
            - Direct Services Offered
            - Issues/Problems in SW/ things needed
            - Onsite Nurse
            - Peer Program/Ambassadors
            - Outreach
            - Stakeholders and funding (government info)
            - Satellite sites
            - Naloxone
            - Advice for other locations
            - Resources
            - Importance of client trust
        - Support (maybe a subsection for referring, interagency)
            - General
            - Referrals
            - Areas for Improvement
        - Crossover
            - General
            - Case work

    - **Inclusivity**
    - **Migrant Workers**
    - **Relationship with Police**
        - General
        - Issues
    - **Political change since election**
    - **Supervised Injection Sites**
- **<u>The Experiences of Harm Reduction Workers</u>**
    - **Emotional Aspects of work**
        - Debriefing
        - Rewarding/positive about work
        - Frustration
        - Emotional strain
    - **Clients and the workers**
        - Client Variability/description, feelings about
            - General
            - Support - two types of clients
        - Admiration for clients
        - Professional boundaries
        - Client experiences

Here one can see several stark differences between the two that demonstrate the utility of the coding process in generating categories and organizing large amounts of data. Compared to the initial set of categories the latter has more depth, specificity, and organized groups than the former. Lastly, categories are further refined by being filtered through the original research questions in order to present data that is relevant to the current study:

- How do the staff describe the service being offered and their experience working for the NEP?
    - General
    - Staffing/admin
    - Direct Services offered
    - Rewarding about work
    - Emotional Strain
    - Debriefing
    - Frustrations
    - Public Opinion
    - Areas for improvement

- How do the mobile outreach services operate and how do the clients know how to identify their vehicles?
    - Outreach

- What is the relationship shared between different staff members and clientele?
    - Importance of client trust
    - Worker's perception of clients
    - Professional Boundaries

- How do interactions and relationships with the police affect harm reduction practices?
    - Relationship with the police

- What strategies are unique to the research site that may be absent from the literature??
    - Peer program and ambassadors
    - Naloxone
    - Satellite sites
    - On-site nurse

- Has the political climate in which harm reduction practices occurred changed since the recent 2015 Federal election?
    - Political change since election

- How do the staff and organization engage with clients who do not speak English or French or may not be from the region?
    - Inclusivity and cultural outreach

This ensures that the data presented are streamlined and coherent while removing categories which, while may be of interest, are not investigated in this project.

Limitations

Unfortunately, this process is not without limitations, some which are mitigated while others simply acknowledged. Given the nature of this short research project, time constraint was a barrier that needed to be worked against; coding was performed on a schedule that more often

than not took longer than the time originally allotted. With more time, there could have been additional rounds of coding and further review of categories. Additionally, performance of more thorough member checking with the participants reviewing codes in order to confirm or deny their validity and to identify any important data that may have been missed or misconstrued would have been beneficial. Lastly, if there was an area deemed important that lacked sufficient investigation then further follow-up interviews could have been scheduled, or possibly more participants sampled if need be.

The second limitation was that I worked as an individual rather than on a research team. Ryan and Bernard (2014) claim that an effective measurement of validity is "intercoder reliability" (p.104) meaning that there must be general agreement between researchers, coders, and interviewers in relation to the generation of codes and the organization of themes/categories. Ideally, this means that the data generated is more likely to be valid and consensually reached rather than simply a product of one particular researcher's bias or subjective worldview. While the amount of data gathered for this project is considerable, the availability of resources and time with which to recruit additional researchers for the data analysis process would have been beneficial to the project as a whole.

Chapter 4 - Findings

As indicated in the introduction, the purpose of this study is to investigate the experiences of harm reduction workers and support staff in the Niagara Region focusing on their work, services, and relationship to both the people they interact with and the locale in which they are situated. With these experiences, the hope is for this research to illuminate the daily operations and challenges of harm reduction and NEPs which may otherwise be overlooked by quantitative studies performed thus far. Therefore, this chapter will present the findings and data gathered throughout this study and will situate them within existing literature to the greatest extent possible; this will be done through in-depth analysis of the themes and codes generated through data analysis. Additionally, since this data covers both support staff and those operating the NEP, "the NEP" will be used to refer to the NEP staff alone whereas "the ASO" is used to refer to both groups.

The themes and categories generated through the data analysis process were organized by the research questions they addressed. While some themes connected directly with certain research questions — such as political change since the 2015 Canadian Federal Election — other unexpected themes which arose such as worker frustration and professional/personal boundaries were organized under the research question they most corresponded with. Ultimately this resulted in seven sections: services offered and the general experience of the workers, mobile outreach services, the relationship between workers and clients, interactions with police, unique and novel strategies particular to this research site, the political climate in which harm reduction is performed since the 2015 Canadian Federal Election, and how cultural inclusivity and intersectionality is used to improve accessibility of services.

The finding in this section offer valuable micro-level insight on the working lives and

experiences of harm reduction staff which have been largely absent from the literature. While data collected on the direct services offered and outreach aspects reinforces existing literature, the wide variety of findings pertaining to the personal experiences of the workers — their frustrations and emotional strain, how they cope with this, their relationship with the clients and the importance of trust, what they find rewarding about this work — illustrates a side of harm reduction that has been seldom explored. Furthermore, the data provides support for novel aspects of the harm reduction program such as the utilization of satellite sites, the operation of a peer program, an efficient naloxone training and distribution program, and the importance of an inclusive intersectional approach which acknowledges differences in gender, sexuality, religion, culture, and language. Lastly, the tenuous relationship between the NEP and the local police is investigated as well, providing insight to the complex interactions between the two and how the former mitigates interference by the latter.

Services Offered and Experience of Workers

General Day-to-Day

While the NEP is officially an NEP it is also described by the workers as a place where clients can learn, feel comfortable, find someone to talk to, and as a community centre for clients. Work is sporadic and unpredictable, alternating between slow and hectic periods:

> **Adrian:** There are no typical days here. Some days it's chaos from nine o'clock right until five. Other times it's fairly quiet in the morning so that's really nice to do your paperwork, your catch-up, that sort of stuff, and then it gets crazy in the afternoon. But it just kind of depends on the needs of clients. Sometimes I'm really super busy with case management, other times it's fairly quiet. There's ebbs and flows. But the days usually consist of dealing with the clients when they walk in, making sure that we have full stock up here, making sure that the van's ready to go, all that sort of stuff.

Employees also mentioned that being aware of current research on harm reduction and best

practices was crucial to providing the best service and information to their clients:

> **M:** Have you guys ever had kind of an exchange system at the site, like a one-for-one?
>
> **Barry:** No, never.
>
> **M:** So it's always just been..
>
> **Barry:** Yeah, I mean they did studies out in British Columbia back in the day and they found it to be actually even more detrimental to the client.
>
> **M:** So that's why you guys don't have that then? Based on the research?
>
> **Barry:** Yeah, research and just common sense.

Beyond formal research, however, learning on the job was also crucial both in terms of learning from clients in the case of contaminated substance outbreaks and being aware of local services outside the agency in order to refer clients. This latter point is important in order to expand the resource pool available to workers when doing case work for their clients:

> **Andrew**: So for resources and supplies generally we're pretty good. Written info we've always got tonnes of. Where I think everything lacks is in referrals. There are very few services so when we're referring out I find community resources are few and far between. So internally I think we do an okay job, sometimes we're definitely overwhelmed, sometimes cases are brand new and we learn as we go, but we're also good at tapping into other resources within the organization.

Lastly, a large part of work involved in running the NEP is simply helping people as they come in and chatting with them in order to build trust and rapport so the service can operate smoothly and effectively.

Administration and Staffing

The employees of the ASO come from an array of sources; while most are hired via the traditional route of resume submission, interview, and hiring, there are multiple notable

exceptions. Some staff were employed from the pool of volunteers that regularly help to supplement areas where labour shortages occur, and are thus already experienced in the day-to-day operations of the NEP. Dan, for example, was employed as a full-time student-worker during the summer period where they would help with the daily work discussed below but would not take part in the case work aspect of the NEP:

> **Dan**: I do volunteering with them [the ASO], so I started with volunteering at reception and then I switched over to the NEP as a summer student and then I worked there full time for the full three months, and then I started volunteering in the the NEP office.

Lastly, Jen was drawn directly from the pool of clients that the ASO services, and helps with the exchange in addition to a number of maintenance and miscellaneous duties.

Administrative duties were noted as a considerable portion that comprise the worker's' daily routine, especially meetings:

> **Barry**: So meetings with community partners, staff meetings, impromptu meetings, we debrief with each other constantly so it's almost like there's multiple mini-meetings between the staff throughout the day. That's the most part of it… Naloxone trainings, if somebody pops in and our trainer is not in then somebody else will do it.

While operating the needle exchange and engaging with clients is what the workers would consider their primary role, this demonstrates that there is much variety in their work as well. Workers need to be in constant communication in order to be up to date on any situation that occurs in the NEP or changes that may be implemented, must discuss future directions the NEP can take, engage and report to community partners working with the NEP, and debrief which will be discussed later in this chapter. Staff also talked about how they dealt with a large volume of telephone calls both outgoing and incoming, in order to perform case work and provide necessary information respectively. Furthermore, the clients who are assigned to each case worker are in frequent contact as well so the worker is aware of the clients' needs and living

situation in order to know what must be addressed. This can however prove challenging since client information may change frequently:

> **Andrew**: Also on that note, changing contact info is always a challenge too. So when I was off for just under a week and my coworkers had left me a few notes of people who are interested in [Naloxone] training, I called them all yesterday and all the numbers are out of service. Every single one.

Record keeping, also colloquially called "O-casing" by the NEP staff, is a daily task necessary to track the number of needles and supplies going out as well as the number of used needles coming back to the site. These numbers are used to secure and justify funding from their sources and to provide an idea of how many individuals are using supplies, the rate at which they use them, and the general exchange rate between supplies going out and coming in. Workers use a "client ID" in order to track individual people who use their services which consists of their first name and their year of birth. Requiring only this information allows the site to perform rudimentary data collection while still protecting the identity of the client to an extent. This ID is not verified either so if a client is worried that releasing personal information such as name or year of birth could harm them in some way they could present false information and still receive supplies, thus not restricting service to only those who identify themselves. While the NEP' data collection is an integral component of their operation, certain situations can arise which may skew data and prevent an accurate depiction of the region's drug use from being produced. For example, individuals who pick up supplies for a number of people and are known as ambassadors – referred to in the literature as a "secondary syringe exchange" (Lorvik et al 2006) – can make it seem like one person is using an exorbitant amount of supplies when in reality they act as a conduit to pass on supplies to any number of individuals.

While participants spoke about the accumulation of work needing to be performed being a constant issue, there tended to be significant job overlap between employees. This means that

despite their multiple roles and specializations, they could fill each other's roles if needed in order to deal with high volume periods or backlog. It also allows for the employees to have flexible schedules in the sense that good communication and job overlap enabled people to take days off and have their roles filled by additional staff or, in some cases, a volunteer.

Direct Services Offered

the NEP offers all the services of a traditional needle exchange such as needles and disposal bins, but also includes a range of other resources that supplement these base materials. This includes a range of needles varying in gauge, length, and capacity, with some being more appropriate for different types of usage, such as use for steroids as opposed to opiates. Additionally, two sizes of biohazard bins are offered; one large bin which can hold approximately 100 needles and a smaller, discreet handheld one which can hold around ten needles are available. the NEP also offers ancillary equipment for injection such as rubber ties to be used as tourniquets, sterile water, alcohol wipes for sterilization, spoons for preparing the drugs, filters for the needles to draw the substances through, and vitamin C powder as an acidifier for the drugs. Funding for these items was noted to come from a variety of sources:

> **Barry**: So public health, they provide us with the needles and the sharps containers, including the cost of disposal of these needles. And all the other harm reduction materials, so your spoons, your filters, ties, vitamin C, all of it comes from the Ontario Harm Reduction Distribution Program, located up in Kingston, and they are funded by the Ministry of Health Long Term Care AIDS and Hep C program so we don't pay out of pocket for that. And the needles and the disposal are part of the overall budget, but that part of the budget is held by public health.

Safer Crack Use Kits (SCUKs) are also in supply, which contain two stem pieces, four mouthpieces, sterile alcohol wipes, pipe screens, condoms, and a push stick, with a sticker on the

front with the the NEP brand and instruction on proper usage of the equipment. The mouthpieces are not prefabricated but rather are cut from lengths of food-grade clear PVC piping which is then affixed to the glass stems which are ordered from a manufacturer; an original and innovative strategy that did not appear in any of the literature reviewed. Lastly, condoms, lubricant, lip balm, and hand sanitizer are also offered in the interest of preventing the spread of disease.

An important factor noted by participants in the implementation of the NEP is the unrestricted exchange policy utilized — clients do not need to bring in used needles in order to receive sterile equipment:

> **Adrian**: So exchange, like one for one exchange is actually not best practice because not everybody's gonna have one [a needle to return]. Maybe they disposed of whatever they picked up the last time they were in at a friend's house or at the outdoor sharps container, or maybe it's still at home. So we don't do that, we do encourage returns and we also hand out the small sharps containers and that sort of stuff to encourage small amounts to come back.

The rationale behind the one-to-one exchange policy is that it will decrease the number of dirty needles in the public and keep the exchange rate high, yet despite not having this restrictive policy the NEP has an excellent exchange rate:

> **Sharon:** in some places they have one to one, one needle, one dirty one in. Us, we gave out so many needles, we got back 82% last year. That's the highest in Ontario, so we're really happy with that.

Returns are nonetheless encouraged and staff are sure to tell clients that the NEP is dependent on them returning their used needles. Keeping track of these statistics and keeping their return rate high is important as it is tied to the amount of funding they receive — if the amount of needles going out increases and the rate of return is acceptable then this proves not only that the amount of funding needed is increasing to serve more people but also that the program is efficient.

Beyond resource distribution, the NEP employees perform case work for their clients as well when required. This removes the anonymity from a client because they are required to give their full name in addition to other information that might be required but allows the employees to advocate on their behalf and assist them with multiple issues. However, there is still a measure of discretion as any supplies they receive from the NEP are still confidential and recorded under the aforementioned client ID rather than being recorded in their case file. The case work staff undertake can involve helping a client find housing or shelter, aiding in filling out forms for social assistance, accompanying them to meetings with agencies such as Canada Association for Mental Health (CAMH), and generally assisting clients in accomplishing their personal goals that they set for themselves. In this way case work is much more intensive than just referrals:

> **Adrian**: Sometimes the clients that walk in this door, we're the only people they feel comfortable talking with, right? And opening up to. So with being able to do that case management we've already developed that rapport so now we can kind of link them up with services and kind of make sure that they're being well taken care of as well as kind of going along the journey with them, not sending them kind of off on their own like "bye! Here's some numbers and names, go for it!" They know the face that they're going to talk to and with the trust that we have with our clients they trust us to link them up with services. If we tell them they're good people, they're gonna believe us and they're more apt to go and follow through with whatever the case plan is.

This case work is also crucial in helping the clients feel empowered and deserving of assistance, to ensure that clients are not "falling through the cracks." Through case work the NEP demonstrates the extent to which NEPs can improve the lives of and humanize clients by doing more for the individual than simply handing out supplies and facilitating used needle returns.

Rewarding Factors in Harm Reduction Work

While there were stressful instances engaging in harm reduction work, participants held their job in overwhelmingly high regard. They described their job as "the best in the world" and

expressed pride in their work as well as their positions within the ASO and the larger harm reduction community. Adrian aptly described himself as a "lifer" indicating that they desired to stay in their position until retirement or at least for a very long period of time, adding that many of their co-workers felt the same.

For many workers, the clients themselves constituted a significant portion of the job's reward:

> **Dan:** The most rewarding thing is exactly that, talking to people, and then them actually trusting you enough to tell you their deepest darkest problems, so I would say that's most rewarding. And then helping them out and people telling us "you guys are doing such a great job giving us free supplies and taking care of us." We had a client who once came in, because he sees the NEP as a safe haven almost, because he did a hit just a few hours ago of what I think was heroin, and he came into the office like "I might overdose, this is the only place I thought was safe enough and you'll take care of me" and we were like wow. Like people would come to us in the needle exchange of all the places —
>
> **M:** Like over the hospital even —
>
> **Dan:** Yeah! Because they know that we would take care of them. So he came in and we sat with him for a good hour, we had everything out just in case he was going to go under. But he was okay, but things like that make me very happy that I decided to volunteer here and then work here.

Workers appreciated when the clients were grateful for the supplies and the service they received, one worker saying that seeing their clients smile after helping them was personally very important. In addition, the relationships that develop between workers and clients are significant — the trust that has been built up so that clients can open up about their experiences and lives, inviting workers into their homes, and regarding the workers as trusted sources of information and support. Workers also claimed that seeing clients make progress in their lives and health was another positive aspect of the work, such as when a client is able to "get clean" and stop using drugs or reduce their usage, or perhaps milestones such as finding a new home or

employment:

> **Bill**: Just to have somebody say "oh my god, if you weren't there I don't know how I would've gotten through this." And I always say "you would've. But I'm glad I was there for you, but you would've made it. You're strong." But "oh my god what would I do without you," those kind of things. "You would so do okay." But to see people smile and especially when people are able to move forward. We've had so many people move forward. Lives are moving along normally with normal problems.

The difference that the workers' labour makes both for their clients and community was brought up as well. Workers saw themselves as protecting both their clients and the public from transmissible disease, as well as reminding clients that their health is important and they are deserving of proper care and treatment. In terms of protecting the lives of their clients, this can sometimes be quite literal in relation to Naloxone, especially if the workers have to, as in rare cases, administer the treatment themselves if a client is found to be overdosing in or around the main office building. Often it is the small day-to-day successes, however, that provide the most rewards of the jobs: getting clients to go to appointments, follow case work direction, or simply going to see a doctor or to a hospital if they are in need of treatment.

Emotional Strain

While the experience of harm reduction workers was generally described as positive, there is emotional stress on the workers as well. This can manifest often as lesser daily stressors but at other times as intense emotional distress. Minor arguments and personality clashes between clients and workers can occasionally occur, causing stress for both workers and clients and damaging the relationship between them. One worker described how it was, in these instances, critical to be able to "put on a mask" in order to hide discomfort and maintain rapport for the greater good of providing service. Furthermore, workers reported that many of their

clients are in a state of constant crisis stemming from poverty, substance use, and past trauma that converge and can be discharged upon the workers as they counsel the clients and listen to their stories:

> **M**: Are there any times that you feel that your job is stressful?
>
> **Adrian**: All the time. With developing the rapport with your clients you get a glimpse into their life, right? So maybe you get a glimpse into why they started using, all that sort of stuff. And a lot of time it's trauma-based so in those cases you hear a lot of heartbreaking stories, you witness a lot of heartbreaking things as well, and it's that kind of stress that you really have to make sure that you debrief with your team, which we're really good at. Make sure you do a lot of self care as well because at the end of the day if you're not good to yourself you're no good to anybody else. And then your daily kind of thing, like the stress of the van and making sure you see as many people as you can and those sorts of daily stressors as well. But I would have to say the biggest stress is just hearing those stories or seeing people in crisis and that sort of stuff because that does happen as well where you're kind of in the middle of a crisis situation and you have to deal with it right then and there.

This testimony demonstrates the daily stress that can be experienced by harm reduction workers, listening to traumatic stories and having to provide emotional support, in addition to the stress of accomplishing daily tasks and making sure a workload does not accumulate. Occasionally, these crisis scenarios are not only instances where the client is in duress, but can be violent as well, necessitating action from the worker:

> **M**: Do any of those crisis situations come to mind as an example maybe? Obviously not anything too specific, but I'm curious.
>
> **Adrian**: I witnessed an abuse situation a while back which was pretty intense so I had to get the girl out of there and make sure she got somewhere safe. I would have to say that's pretty much my most stressful moment.

This is one instance of a particularly egregious event which harm reduction workers may be exposed to. Client lives can often be chaotic and unstable so workers must be aware of difficult and possibly traumatic situations they may have to engage with, and know how to properly cope

through debriefing and self-care. While workers learn to be proficient at managing emotional strain, many expressed that it is difficult not to "bring it home with you."

The health of the workers' clients was also a primary source of stress for the workers. Observing declining client health and relapse of people that they have spent long amounts of time with, in some cases years or decades, can be devastating for some workers and difficult to cope with. At times, the death of a client will occur from overdose or other health issues which can have major negative impacts on workers:

> **John**: The guy who I was working with that died… he was one of my favourite people. He had active addition, he was an alcoholic and had injection drug issues, but he had gotten off of most of the drugs, like he was still snorting a bit of stuff and smoked pot all the time, that was fine, but he was doing really well and we had gotten him into a new apartment. He was feeling like his life was finally coming together, his drug use was under control, he had gotten off of the heroin and the hard drugs, was using some milder stuff, which was part of the goal right? To get away from the more dangerous drugs and just use that little bit of coke or whatever. Then the night before we were to move him into his new apartment he went out and celebrated and used heroin that was probably the fentanyl laced heroin and overdosed. And it was just so heartbreaking because he was celebrating that he was doing better.

This testimony is important to highlight that these factors — client deaths, struggle, and relapse — can all contribute to the daily and situational stress of harm reduction work and engaging with vulnerable populations. Workers have to be careful about how they are managing their emotional stress and coping with tense situations and loss. They stressed efforts to not bring negative emotions and experiences home with them at the end of their shift, and often used humour and joking as a method of coping. Moreover, debriefing was noted as a crucial practice in order to deal with the unavoidable crisis situations and traumatic stories they must experience as they counsel clients.

<u>Debriefing</u>

Debriefing is described by workers as a meeting between two or more workers after an event occurs in order to share information and cooperatively work through any emotional distress that may have been experienced as a result of their work. Events may include hearing a traumatic story from a client, working with a client who is in the throes of a crisis situation, observing something disturbing in a client's home, or simply having a client share information that the worker feels the rest of the staff should know so they can all "be on the same page":

> **Barry**: Debriefing is usually when a client comes in, we're having… not just chit-chat but a more meaningful conversation, maybe they brought forward an issue that they're having, and staff will deal with that and when the person leaves we fill each other in "okay this is where this person's at today, this has happened, so just be aware of that" kind of thing. It just keeps everyone kind of on the same page with what's going on in people's lives because it's important to be able to pick up from that, in that way they kind of know that you're engaged with them and that you care about what's happening to them, that sort of thing. And that's across the whole staff so that way it's not always one person the clients are going to, so if everybody is on the same page then that helps us, and with planning it's like "okay, where are we going to refer this person?" A lot of brainstorming around what's the best plan of care for that person.

Through debriefing, staff are able to stay up to date and consistent with clients, which can also help build rapport. Workers noted that having an amicable and good-mannered staff team is important to this debriefing process, as strong connections of solidarity are needed to provide emotional support. While some members of the support team also reported engaging in debriefing, one worker indicated that engaging in this practice more than is currently performed would be helpful in the future for the reasons listed above.

Frustration in Harm Reduction Work

Frustration was another often-reported experience regarding harm reduction work. First, there was some tension between the agency/management and the workers themselves. Some workers claimed that the agency goals and protocol were different than their own personal goals

which they understood as most beneficial for their clients. For example, certain resources that are not “HIV related” in the eyes of the agency, such as food and mental health services, are not made institutionally available even though the workers perceive them as being integral to the sustained health of their clients. Bill describes how a mental health issue can cause a client to spend their food money on drugs, which leaves them malnourished and with a further weakened immune system thus leaving them more susceptible to health complications:

> **Bill:** Taking care of clients is a holistic thing, so people who live with HIV — like we have a client who is married, has lots of family, has lots of supports, is working full time, this client doesn't need our support, they've got everything. Then take my lady who doesn't have anybody, she doesn't have anything to rely on. A few weeks ago I took her somewhere and she told me she had slipped up again and spent her grocery money. So I happen to have twenty bucks on me and I say “well I have twenty bucks on me, will that help?” and she said yeah, so we stopped by the grocery store and she got twenty bucks’ worth of stuff. And then I come here and I have to fight tooth and nail to get that twenty bucks back. Because, number one the policy and procedure is I'm supposed to ask for it first, and second of all “why are you giving them money for food? That's not HIV related.” Well, kind of. Her mental health causes her to slip up so she needs food to eat to keep up her health, to keep her immune system healthy.

This may be mitigated through more easily accessible mental health services, in addition to funds to supplement client income when needed. In addition to negatively affecting client health, workers were concerned that this lack of mental health resources would damage rapport and leave clients doubting the workers’ ability to truly advocate for and help them.

The other source of frustration for workers was centred around the clients. Some reported frustration with the clients themselves when they would schedule appointments or employment opportunities and clients would fail to attend them:

> **Hannah:** Sometimes it can be a bit frustrating when you’re sort of motivated to help a client and they’re not willing to help themselves and that sounds really awful but it’s true. You can really help someone find a job or find housing and then you find it for them, they finally get it and then they walk away.

More so, however, workers expressed frustration when clients were willing and motivated to attend appointments but the services were not readily available or had extensive waiting lists, as is the case with many mental health services:

> **Andrew:** I find that usually boils down to lack of resources elsewhere. When someone comes in and says "I can't do this anymore" and wants to quit it's one of the most frustrating things, because that is awesome that you're motivated and you're thinking about making a change whether it's going on methadone or heading to detox or going to counselling whatever it may be, but "hey can you wait four months?" That's super frustrating, that we can't jump on those opportunities and give them service right away whether it's through us but we can only do so much with the programming that we have.

Sometimes clients would not be able to afford transportation to appointments as well, as the Ontario Disability Support Program (ODSP) only offers bus passes for medical appointments but not for employment or other enrichment programs. Lastly, workers claimed that the lack of resources for referral was taxing on them, and there was a desire to have a doctor both available on-site and in the van during outreach.

Public Opinion of the ASO and the NEP

Interviewees were conflicted about how the public perceives their service, possibly explained by the dual nature of the ASO as both an ASO and a needle exchange in a single location. On one hand, the ASO as an overall organization has a positive local image as a service provider and a charitable organization, whereas the NEP is cast in a more negative light because of its association with and perceived enabling of drug use. Stacey explains:

> **M**: How do you think that the general public views the ASO?
>
> **Stacey**: I think they probably are more acceptable of the the ASO side rather than the the NEP side. the ASO, if you ask people what that means, those are the people that help the people that are HIV positive and that's a good thing, but then when you go to people talking about the the NEP program and those are the people that are helping IV drug users. A lot of people think it's enabling, a lot of people think it's not right. So probably

there's a positive and a negative.

Here one can see how the ASO and its workers have to navigate an oftentimes conflicting organizational identity. This combined with misconceptions and stigma surrounding the needle exchange can polarize public opinion:

> **Adrian**: I think with harm reduction in general I think it's either black or white, people either really strongly agree with it or really strongly oppose it. There's never really anybody that says "eh, I could care less." Either people are really for it or they're against it and that's even with this program too. People really get it or they don't.

The ASO works to reinforce and improve their organization's image through engaging with the public via outreach in the form of information booths at events, workshops, and awareness initiatives. This includes initiatives such as the Red Scarf Campaign in which members of the public were encouraged to use social media to increase the visibility of the ASO:

> **Andrew:** I don't know how much the general public would really know about us. I think that's something that we're always trying to improve through things like the Red Scarf Campaign and stuff like that but yeah it's [publicity is] generally helpful I would think.

One aspect of public perception of the ASO that most participants expressed is that they are largely "under the radar," or operating outside of public consciousness:

> **Sharon**: I think we're under the radar big time, I think people hear about a needle exchange but have no idea about the volume of stuff that goes on. I think that they like to think that there's only a few addicts where my guess is in the Niagara Peninsula there would be ten to fifteen thousand addicts, active users. And every drug you could think of.

> **Dan**: From what my experience is from the few times I've gone out in the community whether it was to talk about the organization on Canada Day, or the Fort Erie Friendship Festival, or Pelham festivals or whether it's more like going on donation runs, a lot of them don't really know we exist, a lot of the community members don't know that there is an organization called PLN that helps people out with HIV/AIDS, so they don't really know of us and when I tell them about what we do they're kind of like "oh I didn't know we even had something like this available," so a lot of them don't know who we are and

that's the gist I get from the community.

Unlike other health institutions such as clinics and hospitals, the ASO and the NEP are often overlooked. Participants noted that there was little awareness of their site in the general public; there were misconceptions and a lack of knowledge regarding what services were offered and the scope of their operation. Some participants noted that such a discreet status may be effective for avoiding potential resistance from detractors, but ultimately it may be detrimental to service implementation:

> **M**: Do you think that works to their advantage in a way, as a needle exchange?
>
> **Dan**: That people don't know that we exist? I don't know, I would say that a lot of times when I've told them we are a needle exchange I get a lot of "ohhh, that's… interesting." It's not like a really positive reaction. So I guess you could say in that sense that we don't get a lot of hate or negativity from the community members, but it's also not the greatest that people don't know we exist because that means we're not reaching out to all the people out there that we could be.

These responses demonstrate that while there are some who acknowledge the advantages of low visibility, it can reduce the effectiveness of initiatives to provide outreach and education. Furthermore, low visibility could possibly preclude the chance to sway the opinion of the public in a favourable direction regarding harm reduction service providers.

Issues and Areas for Improvement

While there are many benefits of the ASO's services there are also gaps that need to be filled and issues to be resolved. Many of these pertain to lack of services and the limited number of staff available to explore known services and referral options, or research undiscovered services that may apply to a client's needs. All the NEP staff interviewed expressed a desire for more labour and staff to be made available to relieve workload and increase the quality of

services offered:

> **Adrian**: Of course, everything can always be improved, right? The amount of staff in this program could always be increased for sure. We're one of the busier programs, we have over 400 unique identified clients, over a thousand contacts in a month. We're busy. And we accomplish a lot for a staff of four, we do, but I feel like a lot more could be accomplished.

Labour shortage was noted by one participant to be one of the most significant barriers to the expansion of service. With 400 unique identified clients and over 1000 contacts per month, the NEP staff are occasionally overwhelmed by work, records keeping, outreach, and client volume.

Referrals and community services were quoted as being crucial for the general community that the NEP engages with. Medical services are often negatively impacted by stigma — not offering treatment, medication, or antibiotics to clients with signs of drug use, thus creating an avoidance of medical health services in the clients:

> **Sharon:** There's no travelling doctor, there's no way too — the only place they [clients] can get help is the emergency room, and of course they're treated like crap when they get there because they are stigmatized because they are drug addicts. Like they immediately look at their arms. If there's track marks then they're out. They're not going to prescribe them anything for pain so like what do they do? Give them a band-aid?
>
> **M:** Yeah especially for the mental health stuff.
>
> **Sharon:** Oh the mental health stuff is out of control. Of course they won't treat mental health before they treat the addiction, even though they are completely intertwined. They're brother and sister. The reason they are addicts — and the mental health issue gets more difficult and complex the more they use.

Furthermore, medical services for mental health are extremely restricted and lacking, with little help in times of crises as the waiting list for support is over six months long according to participants. Clients report to workers that hospitals will not treat mental health issues until addiction issues are resolved first, although harm reduction workers claim the two are intertwined and inseparable and must be treated as such. Lastly, there are significant issues with

lack of housing among the population of people who use drugs:

> **Andrew**: We need to have a damp shelter, all of the shelters in town are zero tolerance, every single shelter is zero tolerance, so if you are using you get kicked out. Some are a little more lenient even though the policy says zero tolerance but there's… first off there's a lot of people who don't have a place to go use [drugs], so they're rushing and that causes other problems like abscesses, misses, overdoses, that kind of thing, that's not safe. If they have nowhere to go in terms of a home, somewhere to sleep, that's not a good thing. And if it means that they are high when they're walking in then they are high when they're walking in, they still need and deserve a good place to sleep.

Overall, there is a general need for more services to refer to, a need for more community resources available, and a desire for less fragmented community agencies as well as more collaboration in order to bring better service provision to clients.

On a final note, one worker expressed that they wished to see better integration of clients in the workings of the ASO and the NEP itself. While volunteers can in some cases be people who formerly used drugs and were former clients, there are no active users, a situation that this particular respondent would like to see remedied beyond the peer program and ambassadors.

Mobile Services and Outreach

Outreach to clients through multiple channels is considered an integral component in providing accessible service to clients who may not use the fixed-site office or only do so occasionally. This also provides an avenue for clients who have mobility issues, stemming either from medical conditions or lack of funds for adequate and convenient transportation. While there are many opportunities through which the performance of outreach is achieved, the primary method is through a mobile van service operated by the NEP staff.

The van operates as a mobile needle exchange, offering generally all the services and supplies that the fixed-site location does albeit in smaller quantities in order to ensure all clients

are served despite the van's limited capacity. Clients may find out about the service in a number of ways:

> **M**: And how do people contact the van originally? Like first contact?
>
> **Barry**: Way back in the day we had a pager! So either they would call the office or the pager, now it's just by cell phone or they can call the office and leave messages with one of the staff and they'll get added to the outreach list for that night.
>
> **M**: How do people normally make their first contact with the van? Like do they come in here and then find out about it or..
>
> **Barry**: There's no really usual way, that happens sometimes when they come in here and might not even be aware that we have a van, so that's when we start talking to them and tell them their different options, if they can't make it to the office then there is the van, there is the satellite sites, that sort of thing.

Additionally, the clients could find out about the mobile service through outreach and advertisement, word of mouth, or the presence of an ambassador in their life. Clients can arrange for a home drop off by calling the the NEP organizational cell phone or the fixed-site office in order to be added to the list for that night. In the interest of being discreet, all that is needed from the clients to receive supplies is a name, address, and their supply order. The van covers the entire Niagara Region continually:

> **Sharon:** Our responsibility is the entire Niagara Region including all the outside — Grimsby, Fort Erie and all the way around. And we just go, you know? Start calling. But you know, like I know pretty much everybody, they're on about a two week, two and a half week cycle, I see pretty much everybody. But the nature of our community is that one person will be the hub, and we call him the ambassador, like I'll give him 500 needles and he'll distribute them to his little crew, or they all use in his place.

This also means the staff sometimes have to drive upwards of forty minutes in order to reach some clients, and thus to save time outlying areas in the region are serviced twice a week while St. Catharines and closer areas are covered daily over the whole week with the exception of

weekends.

There are no fixed staff who solely perform van duties; shifts are changed regularly in order to spread the burden of work around and to have clients become familiar with multiple the NEP staff. Van duties are restricted to the NEP staff at night, however during the summer student staff are allowed to drive the van in the afternoon. As a general rule, only one person is required to bring supplies to satellite sites though two are needed if they will be servicing a client for safety purposes. Additionally, professionals are occasionally brought along on van outreach in order to provide services directly to the community:

> **Sharon:** I have a product they need so I get invited into a lot of places that most people wouldnt maybe. And when I'm dragging a nurse with me or an addictions counsellor even better. I also travel around once a month with a pharmacist and anyone who has questions about types of drugs and stuff that they may be using and the combination of them, has the guy right there.

The van outreach service is noted as quite popular, with hours having to be extended past normal times in the past years. Participants noted that they were fortunate to be one of the few NEPs out of 64 in Ontario to offer house calls and that this service was important for building relationships with clients:

> **Adrian:** We're one of the few in the province that has a model of the outreach that we do so we're able to go into people's homes and things like that. There's very few needle exchanges that do that as well, some will stop at a set location and be there for a certain amount of time but we find that by going into people's homes we develop that rapport, we develop the trust and we get to know the people as people and we get a lot more information and we get a lot more work accomplished in that way too.

Workers described the outreach process as a necessary one in which they were able to step into someone else's reality, and felt honoured to be trusted and welcomed into people's homes. It was seen as not just taking care of clients but becoming part of their life, however briefly, and providing them with what may be the only sober contact that they trust and can talk to.

Aside from the van outreach, many other avenues are explored in order to increase the visibility and accessibility of the NEP. Within the fixed-site there is an information board with updated information on drug safety and reported contamination, which is also included in a quarterly newsletter distributed to clients. If there is a significant and time-sensitive outbreak of contaminated drugs and the newsletter is not planned to be immediately distributed then a special supplementary warning will be issued. Clients are often trained to use Naloxone in their own homes in order to better reach them:

> **Andrew:** Well the structure of the program is really cool, just like the rest of the NEP it's an outreach model so I would say up to 95% of the trainings I do are in people's homes throughout the region which is really nice. Obviously Naloxone is used to reverse an opiate overdose and right now we have just under 400 clients trained to use it which is wonderful, and 254 successful reversals which is also wonderful, and scary.

The high rate of outreach trainings and the significant number of clients trained strongly support the efficacy of such programs rather than training sessions at a fixed site alone.

Many social gatherings were used as facets for outreach, with staff setting up information/education booths at sex trade shows, Canada Day events, and the Fort Erie Friendship Festival in addition to others. Furthermore, branded items such as pens were distributed to people who frequented these booths in order to increase the public visibility of the ASO and the NEP. Lastly, outreach was undertaken at places such as food banks where clientele could be reached in order to distribute supplies, perform education and training, and generally build rapport. Workers claimed it was important to be socially aware when performing this type of outreach:

> **Andrew**: So a tonne of it is rapport building, because you have to build that trust up to begin with and then yeah, a lot of information about safer injection, drug info, so right now we know that Fentanyl is going around so having those conversations with people. Some people don't want to hear it and that's fine, that all depends on your relationship with them and what they're up to and what their day looks like.

This demonstrates it is significant to know when and when not to speak to people, to be aware of one's relationship with them if there has been a previous encounter, and be sensitive to their general mood and how their day was going in order to make a connection and build rapport.

The Relationship Between Workers and Clients

The Importance of Client Trust

Much like with Stacey's medical service, the importance of client trust cannot be overstated. The criminalized status of drug possession and stigmatized nature of drug use contribute significantly to a general mistrust in clients of government services, especially those that they perceive or assume to be connected with the police:

> **Andrew**: If they don't trust you they're not going to walk through the door. We see it a lot especially with new people, there's that fear that we're linked to the cops, the clients know what they're doing is inherently illegal, but they learn pretty quickly that they can trust us, I think, I hope.

> **M**: Would you say that trust is important, and how come?
>
> **Barry**: It's imperative. Because folks are engaging in behaviours that are illegal in some cases, there has to be a great amount of trust there for them to start opening up and talking. They have to understand that we are not police, we are not affiliated with the police, we do not talk to the police. And what they say is going to remain confidential.

This confidentiality is also important in order to get clients to utilize the NEP. While name and age are tracked for the purposes of records and evaluation, no further identification, government issued or otherwise, is asked for. If identification is asked for or if confidentiality is breached, clients know they could be putting their lives, jobs, and perhaps even families at risk as seen in one case where FACS was notified regarding a client and they had their children removed. As

illustrated by the evidence above, this case could have been especially problematic in that if the police removed the children, then the satellite site and thus the ASO and the NEP would have been associated with the police, severely damaging their reputation and the rapport with their clients built up over more than a decade.

This client trust is central to the operation of the NEP because, quite simply, if there is no trust then clients will not utilize the site or their outreach. Furthermore, it enables and encourages clients to be open with the NEP staff, thus providing them with valuable channels of information through which they can be made aware of contamination crises or other occurrences of note in the community. It allows for clients to be part of the work of harm reduction practices, provide feedback about services, and provide direction for future growth, as well as increasing the visibility of the ASO's and the NEP' services through word-of-mouth:

> **Adrian**:Word of mouth is huge in this program. We've got pretty good street cred and I think that's super important because if you don't, you're stuck, especially within this community.
>
> **M**: How come? Like what would happen if you didn't have that?
>
> **Adrian**: Nobody would call or if they do call it would just be like a, "here's your supplies, I'm gone" and that's it. You wouldn't have that open dialogue, conversations. Because our clients are the ones that tell us about stuff. They tell us, you know, "the heroin out there's extremely strong, people are going down left right and centre" or "I bought this oxy but I don't think it's real, what do you guys think?" They're the ones that know. They're the experts. They're the ones who inform us and help us.

An additional benefit of building rapport is that if a client breaks contact for whatever reason, if they return and contact the NEP or the ASO the workers are prepared to "pick up where they left off" in terms of case work or Naloxone training.

This trust is fostered through a number of ways, many of them taking a significant amount of time to establish. Most participants claimed it took approximately one year from the

start of their employment for clients to feel comfortable with and able trust them in a way comparable to workers with more seniority. The first method of building rapport and trust is to ensure that the clients see the NEP as their space — a place they can come to and be safe, to talk, and especially not be judged by the staff. The space was made to represent the clients in even small ways — art created by the clients was displayed in the office (as seen in figures 3 and 4) and also a small information board with phrases such as “Harm reduction is more than handing out equipment. Much more.” and “It is not just about veins. It is about people”.

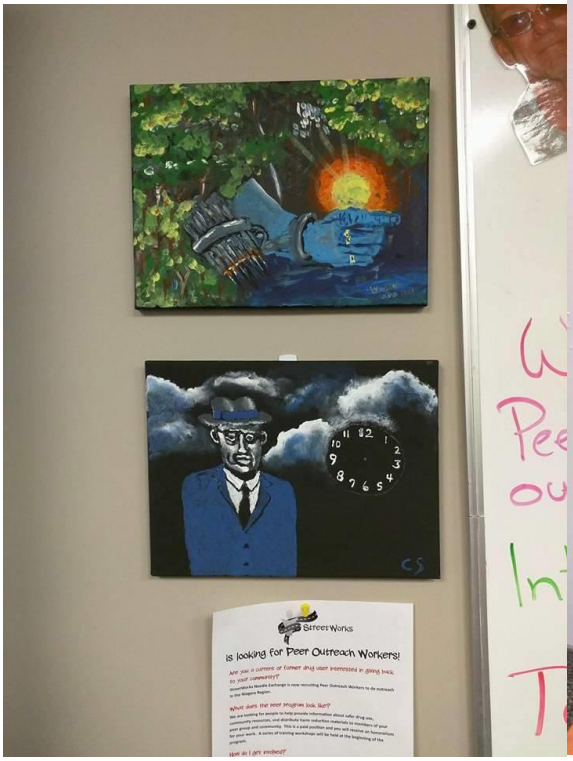


Figure 4 - Client Art

Figure 5 - Client Art

Second, clients may come in during times of crises so staff need to be prepared for that to a certain extent, in order to provide some counselling and referrals for outside services if need be. Third, social strategies can be used to be more personable and open to clients. For example, one common tactic that came up in interviews was the practice of remembering at least one thing about each client:

> **Andrew**: It's a way of getting to know them in a way, something that [a colleague] said that always stuck with me is “yes they are people who use drugs, but they also have everything else going on with their lives” right? A sister who commits suicide, a sick father, a dog, a cat, whatever it may be. So they're still dealing with everyday things in addition to using. And so trying to remember one thing about everyone is important and slowly you can build that trust and have them think “hey, they actually care”. And at the end of the day we do definitely care, but that's a way of showing it to them like “oh how’s your dog doing, he wasn't feeling well last time you were here” and then suddenly you're talking about the dog and then somehow you're talking about Hep C. So it's kind of that bridge into more communication which is strange and wonderful.

This demonstrates how building trust and relationships with clients can have tangible results in terms of raising awareness about harm reduction and health in general. A fourth method is a community newsletter is produced every three months not only to spread information and warnings about contamination but also to showcase client success stories, art, and other client-centred material. Lastly, the manner in which employees conduct themselves has an effect on rapport and client trust:

> **Dan**: There's a huge trust factor involved. If you're going to be very professional towards clients then they aren't going to be able to open up to you at all, they're not going to tell you their problems, they might not even walk through your door if you're going to put up a very professional front. Like we have to be professional up until a certain point but there has to be a personal aspect to it as well so doing things like that, the magazine, asking people and talking to them about good stories that they have, that builds a personal connection and they're able to trust you more after that, you know?

On a basic level harm reduction workers should be personable and friendly while of course still maintaining professional boundaries and conduct. A worker who is emotionless or simply sees the client as exactly that — only as a number or client to be served and recorded — precludes the possibility of rapport being built and establishes the NEP as little more than a dispensary for supplies.

Workers Perception of Clients

Generally, harm reduction workers both from the NEP and support perceived their clients as people who are stigmatized, non-judgmental, and appreciative of their services. Workers were quick to reassert that their clients were “human beings” and “people,” thus reaffirming their humanity and ultimately implying that they are deserving of service and care despite being stigmatized by society at large:

> **Andrew**: The clients in general are very kind, very lovely, we’re some of the only people they trust because they have accessed services in the past elsewhere and they have not been treated well. They know that they can come in and talk openly about whatever and we will not judge them. They've got fascinating stories, some are sad, some are funny, there's a huge mix. They're people, we’re just working with people who happen to use drugs. But yeah, they're really wonderful.

The respondents understand that clients oftentimes faced multiple layers of intersecting stigma as drug users, are often impoverished, and sometimes carry diseases such as HIV or Hepatitis C.

Support workers often perceived their clients as being part of two general groups, based on socio-economic standing. Clients who occupy a higher socioeconomic status tended to contact them approximately once or twice a year, usually in order to be connected with a specialist or other service that they are not able to procure themselves. Clients who were struggling economically or living in poverty often had multiple forms of oppression and stigma acting upon their life as mentioned above. This can include addiction, mental health issues, being HIV positive, sexual orientation, gender (if they are women, trans-, or nonbinary), or if they have a disability. While there is a large variance in type of client based on multiple intersecting factors, these two groups were identified as consistent in their work.

In the NEP clients are described similarly as heavily stigmatized, with often chaotic lives who see the NEP as a safe haven where they can go for help without judgement. Unlike support,

the majority of the NEP clients are in poverty or belong to a low socio-economic status as most people in the middling or upper classes are able to afford supplies without going to the the NEP office — an act which can be considered stigmatized itself:

> **Dan**: Well the thing is that a lot of them belong to a poor socio-economic group so a lot of them can't afford to go to places that charge them for the needles that they use, a more sophisticated place. So we do give free clean supplies, so a lot of people are really grateful for that. And we don't pass on judgement, we respect confidentiality, and there's no questions asked in what they're asking from us, so the people appreciate that as well.

Clients are perceived as pleasant and helpful to staff, sometimes irritable, but workers noted there have rarely if ever been any altercations in the office. Some clients are seen regularly while others can fall out of contact for years before they come back in for more supplies or other resources. One worker described how some clients were even generationally linked, with the children or parents of clients also receiving supplies for drug use. Ultimately, workers were adamant about reaffirming the normalcy of their clients, their positive traits, and admiration of their success over their struggles.

Professional/Personal Boundaries

The close interpersonal bond that can form between the workers and clients, a result of the intimate stories that are shared and the trust that is developed, can sometimes become problematic and impede service if not properly managed. Many of the clients see the workers, especially their specific case worker if they have one, as friends or even family and thus certain boundaries need to be set by the worker in order to maintain a healthy relationship that facilitates rather than negatively impacts their labour:

> **Hannah**: There’s things I’d like to share with this group and that is as much as we become close to our clients we have to be careful of boundaries because they will allow us and sometimes we can allow them to really cross boundaries because they almost

> become familial and that's not going to be a healthy thing for them or for us. We've got to learn to leave work at our jobs and not take them home with us or just carry them with us a hundred percent of the time. I'd say that's probably the biggest thing for me. Like when I close the door I can go home at night. I don't fake it to them, but at the same time I'm not going to be giving them my home phone number so we can chat at seven o'clock at night.

Workers were insistent that their emotions were genuine, but maintaining these boundaries is part of their self-care so that they are not "bringing their work home with them." Sometimes this proved difficult, however, with one worker expressing their surprise the first time they had a family member or friend come into the office for supplies or information. In cases such as these professionalism can be maintained but it becomes more challenging than engaging with a stranger that the worker had met specifically through the ASO.

Interactions and Relations with Police

Workers' perspectives on the relationship between the police and harm reduction service provision are mixed and oftentimes complex. As noted previously, the ASO was cautious about being seen as having any relationship with the police as it may negatively affect client trust. However, as the police are heavily involved with enforcing legislation involving drugs and the people who use and sell them, their presence must be taken into consideration. Additionally, employees of the ASO and the police sit on multiple committees together, thus further necessitating some level of collaboration and dialogue. General relations with the police were described as cordial, relatively amicable, but also varying from officer to officer:

> **M**: What the relationship like between PLN and the police in the area?
>
> **Barry**: I mean, we consider them a community partner, we sit on one or two committees with police, it's cordial I would say? We've always had the support of every chief of police since the program started, and have a letter in the van stating that this is what we do and they're fully aware and support our efforts to curb the spread of HIV and Hepatitis

> C. Does that translate down the rank and file? No. Some officers are wonderful, they totally get it, and others don't and never will but that's par for the course.

The letter written specifically for the van outreach is important as it allows workers to bypass any officers who may not know of the program or do not agree with its goals and values in the case that they are detained and questioned about having drug use supplies in the vehicle. While some participants were cautious to characterize the relationship with the police as anything more than lukewarm, many claimed that the relationship is steadily improving. The ever-growing opiate crisis in Niagara may be understood as a catalyst for changing relationships with the police as well:

> **Stacey**: I do know they've had the talk with the police force about the Naloxone program and that Naloxone kits should be allowed; they shouldn't be confiscated. I think the relationship between the police and the NEP is getting better because really we should all be working together to fight the overdoses and the drugs that are out there but yeah you're still gonna get police that either don't understand, don't want to understand, don't want to learn, still see the NEP as enabling, making their job harder.

With the onset of the opiate crisis, public safety concerns and the desire to proliferate Naloxone to a greater extent has opened up conversation between the harm reduction community and police. Political intrigue in these issues may force police to seek help and collaboration from the harm reduction community in order to generate a more proactive solution than enforcement alone. However, because of the drastic differences between the mandates of the police and harm reduction there have been tensions nonetheless:

> **Andrew**: Beyond these walls the cops are a… challenge, no doubt. As I mentioned earlier our mandates are just polar opposite, they're trying to do their jobs and we're trying to do ours. We are in more communication now with the cops, trying to improve things and work on things together, frankly we do have an opiate crisis in Niagara, like the rest of Canada at this point. It is not unique to here, so we need to work together.

Aside from the conflicting mandates, there have been past reports of police confiscating

Naloxone kits, which can severely disempower clients and threaten their safety, although this has since ceased to be an issue at the time of this study.

There have, however, been more serious issues with the police which have occurred. One participant claimed that police were active in intentionally stigmatizing HIV positive clients, for example, wearing gloves when performing duties in locations in which they know an HIV positive client resides. Furthermore, the police have at times parked their cars or arrested people near the ASO's location which can damage trust and rapport, with clients avoiding the location in consequence. Lastly, police were recently reported to have performed a "sweep" of the area in which the ASO and the NEP operate, arresting multiple sex workers for allegedly impeding traffic and "redzoning" them from the area. While the case was ultimately dismissed by a judge, this redzoning can impede clients from accessing the services that not only the ASO provides, but also housing, food, and other services in the area that are often used by their clients:

> **M**: Did that affect your services at all?
>
> **Barry**: No they were red zones, some of them. So they could not be seen in this sort of geographical area, I forget the parameters, but because we do have the ability to do outreach we could go to them.

This underscores the utmost significance of having constant outreach services available to clients, as the NEP was able to circumvent the redzoning by going to the clients directly. Workers reported frustration at the waste of labour and resources used in performing the sweep in the first place, further demonstrating the differences in their mandates with the police focusing on enforcement, and harm reduction workers focusing on service provision.

Unique Strategies and Practices

Peer Program and Ambassadors

The trust built through the previously discussed methods is important in relation to recruiting ambassadors and establishing a peer program that works in tandem with the NEP and the ASO. Ambassadors, as previously discussed, are regarded as community liaisons who not only provide supplies for those who cannot or will not visit the NEP or a satellite site themselves but also provide information on the community, contaminations, and feedback for ongoing programs such as Naloxone or a peer program. These ambassadors are sometimes given compensation in the forms of gift cards and can also be provided with a certificate outlining their contributions to the NEP and their community which can be very personally meaningful.

The peer program occurs twice a month, and is an opportunity for clients to be involved in the NEP while receiving compensation. This involves two hours of their time in a group in which they participate in SCUK construction to later be distributed through the NEP to other clients. Clients are chosen based on a lottery system and are given a twenty dollar honorarium, an improvement on past models which only involved sporadic compensation. While this is progress, there were some staff who expressed a desire to see the peer program role be made into a proper staff position with consistent wages:

> **Andrew**: They're giving us valuable work, we cannot make that many inhalation kits on our own, we need the help, we need about 450 a month and we can't do that on our own. And it's nice for them to feel valued, right? It's not an official staff role, would that be nice? Sure. With proper wages? Sure. But yeah that connection piece is really nice and they're actually being active in giving back I mean the information is wonderful.

Much like the ambassadors, the peer programs are excellent sources of community information and feedback. Programs such as the Naloxone distribution and equipment such as

certain types of needles or the SCUKs can be evaluated in part by the reactions and feedback generated in these peer program sessions, providing information for future development and alterations that may need to be implemented. Clients are understood as expert knowers who are able to provide insight on drug use, Naloxone utilization, and ongoing contaminations within the community. For example:

> **Andrew:** So earlier in this summer we were hearing that all the really strong stuff smelled like burned popcorn, it was easy to pull that data. So we say to people "look that information is super helpful so what you're teaching us we're able to go to other people and say "hey if you're breaking your shit down and it smells like burned popcorn be careful, it's probably really strong." And they see that happen, they know that they've given us information and then it goes on the whiteboard or it goes in the newsletter, so it's a way of trying to keep people engaged in frankly *their* service.

On a final note, these peer sessions are used as a channel through which clients can be taught about diseases such as hepatitis C and HIV, as well as raising awareness about general health.

Naloxone Program

The Naloxone training and distribution program which started in August of 2013 was designed to prepare and equip clients to react and aid themselves or others in an opiate overdose situation. Naloxone is an opiate antagonist which in one or two doses is able to clear opiates from neural receptors which can consequently allow a person experiencing an opiate overdose to breathe again while waiting for further medical assistance. Funded by United Way, this program involves a training session with a harm reduction worker before the client is given their own Naloxone kit for free which uses either nasal or intravenous administration methods. While previously this resource was only available to those who have used an opiate in the last six months or by a doctor co-signing, restrictions have since been lifted so that friends, family, and caregivers can utilize the program as well. Additionally, training sessions have been performed

with service providers such as homeless shelters, the Canadian Association of Schools of Nursing, and the John Howard Society.

the NEP is fortunate to have dedicated employees for the purposes of Naloxone training and distribution. Training takes approximately half an hour and uses water vials to represent Naloxone and stress balls in order to create a mock injection scenario to familiarize its users with the process. Training can either be done at the main the ASO office, as outreach in a client's home, or through one of the satellite sites that opt-in and are equipped for training and supplying those interested. Satellite sites, often utilized by friends and family for Naloxone training more than clients, require a government issued health card and provide a shorter training session than the official trainer, often spanning only five minutes. Some participants were concerned that this would lead to ineffective usage however this remains to be verified.

As a high uptake program, slightly less than 400 clients have been trained, over 400 kits have been distributed, and 254 reversals performed at the time of this interview, demonstrating the effectiveness of the program and its concordant need within the community. Interviewees were quick to note the positive effects of having this resource in an often life-or-death scenario:

> **Sharon**: It's been a good thing and without the Naloxone you wouldn't believe how many people I would have lost, it's scary. Every day I'm hearing about it — and these are the ones we know about! We don't even know about half of them.

> **Andrew**: Everything, I have the best job in the world. For the Naloxone program I am really, really fortunate to get to talk to people who have had essentially their lives saved because of a program that I happen to be lucky to have been at the right spot in the right time to get the job.
>
> **M**: Yeah, like right up there with paramedics and stuff.
>
> **Andrew**: Yeah! Like — I just got goosebumps — yeah like one guy up in Thorold, he

was like “that shit saved my life last night” and to hear that is really nice.

Interviewees also reported that clients felt empowered and showed great pride in the training they received and their ability to be prepared:

> **Andrew**: With Naloxone we see a lot of the clients feel super empowered after they do the training it's really cute when I'm out in the van sometimes they have their certificates on the wall or on the fridge and one person has it framed on the wall, and so they feel empowered and that they've learned something and that they are part of a community.

This shows that clients are benefited in more ways than simply the medical benefit of having Naloxone on hand. The training and power to have influence over what is often a terrifying possibility, overdose and death, is representative of the more holistic aspects of harm reduction strategies. These aspects — empowerment, awareness, and education — are often overshadowed by quantifiable benefits such as the prevention of disease and death, but are nonetheless important to consider as well and have an effect on the lives of the clients and their community.

However, there have been obstacles to overcome with this program as well; constantly changing client contact information presents a challenge for training and the dissemination of supplies. Furthermore, Naloxone usage is likely underreported and discrepancies in the availability and recording of data regarding overdoses can obfuscate the scope of the problem being addressed. For example, drug user overdoses and deaths can often be recorded as suicides and it can take extensive time, years in fact, to access the data necessary to effectively implement a solution. Workers expressed a desire for greater collaboration between stakeholders with data available in order to generate real-time data to better understand the scale of drug-overdose deaths and to evaluate current and future solutions.

Satellite Sites

Part of the NEP that may be considered another form of outreach is the inclusion of satellite sites which act as fixed-site offices to supplement the main the NEP branch. These sites provide many of the supplies that the main office does, but with the added benefit of being geographically distributed so clients can more easily access them without having to pay for transportation or spend time and energy walking long distances. There are nine sites in all, many of them pharmacies with some dispensing methadone, although some other locations are used as well such as sex worker drop in centres. Having methadone dispensing pharmacies participate as satellite sites is important because it allows such sites to be visible to clients who visit the site frequently and can refer people they know who may also need supplies:

> **Adrian:** We also have some satellite sites, I think we counted nine, so most of them are methadone dispensing pharmacies in the area that carry our supplies. So maybe somebody doesn't want to come into our office, or it's a weekend or statutory holiday or whatever so people can go in there and get limited amounts of supplies, they're not going to get boxes upon boxes but they'll get enough until we can see them.

The satellite sites are also beneficial in that they are often open on holidays and weekends, times when the main the ASO office may be closed. They are able to distribute and perform training for Naloxone as well, which provides added coverage for that program. Workers reported that these sites generally tended to contact the ASO in order to opt-in to the NEP program, rather than the ASO reaching out to them.

There have, however, been some issues with the satellite sites. The staff working at the satellite site may not be vetted or trained by the NEP, have access to the same information, or have the same values as those who work at the NEP every day. One particularly disturbing incident was reported as an example of why this can cause problems:

> **Sharon**: Some are more effective than others based on staff, because a lot of them at night they tend to use eighteen year olds, highschool kids, stuff like that and they don't know what the heck they're doing, they don't even know it's there. Not their fault mind you.

> **M**: For sure, how does that affect that though?
>
> **Sharon**: Well it affects it a lot because they aren't trained in confidentiality, a lot of people won't go into their local pharmacy because that's where they get their prescriptions, stuff like that. And one of the guys who went into our satellites they called FACS [Family and Children's Services] on them and he lost his kids. Bad bad bad.

This demonstrates how differences in training and personal values can negatively affect client trust and rapport and thus impact the entire harm reduction operation. Breaches of confidentiality such as this can destroy years of trust that organizations such as the NEP and the ASO depend on and must be taken very seriously. Despite this instance, however, the satellites were reported to generate positive results and most treat clients as they would any other patient that frequented the pharmacies.

<u>On-site Nurse</u>

One service that is often not available to NEPs is the presence of medical staff such as nurse practitioners or doctors. Nurse staff also provide referrals and counselling in ways that NEP staff often cannot without the same breadth of knowledge and experience in the medical field. the NEP is one of few NEPs which are able to offer access to an on-site nurse in order to fulfill the needs of the clients in this respect.

Stacey is the nurse practitioner who works with the ASO and the NEP to provide medical care to clients and has agreed to be named for the purposes of this project. Employed by Regional Public Health, she is on-site at the ASO once a week to utilize the space as a way to increase her visibility and accessibility among the drug using population — a crucial factor in providing effective public care. From her private space in the building she is able to provide vaccinations, influenza boosters, tetanus shots, basic wound care and evaluation, counselling,

referrals, and testing for both HIV and Hepatitis C. Furthermore, she is able to step in and dispense injection supplies and other materials in the event that the the NEP staff are not in the office. As a supplementary form of public health outreach outside of her on-site hours, Stacey is also present in the outreach van once a week in order to provide care in homes, parking lots, or wherever the clients feel most comfortable.

This client comfort and the trust that it requires are of utmost importance not only to the clients but also to Stacey in order to effectively perform her role as a public health outreach worker. Many clients of the NEP have experienced stigma from the medical community because of their drug use, either being chastised or even refused treatment in rare cases. These negative experiences can affect their perception of healthcare services, an image that Stacey works actively against:

> **Stacey:** They're very appreciative of the work that we do and the services we offer them because in other instances they've been judged. They've been looked down upon, turned away, so to have professionals that will help them and not judge them, they're very appreciative.
>
> **M:** Yeah i've heard some horror stories about like doctors and the ER and…
>
> **Stacey:** Awful. Awful, awful. And having a nurse there is very helpful to those clients because they have had very bad experiences in the medical field. So sometimes what they need to see is a good experience and they need to see that not all nurses and doctors will be the same, and when they trust me then after that if there's something I can't provide them then they're more likely to go places that I refer them to because I'm referring them, and they trust me so they must trust whoever i'm referring them to.

In the case that a client is still uncomfortable with a referral, Stacey can perform a “warm transfer” in which she will physically go with them to the medical appointment or hospital if they so desire in order to ensure that it goes well and the client is respected. This trust allows Stacey to act as a medical advisor to clients and guide them in ways that general medical staff at a clinic

or hospital cannot, thus producing effective results. Furthermore this treatment and attention provides personal empowerment:

> **M**: How do you feel your work affects the clients who come into the ASO?
>
> **Stacey:** Boosts their self-esteem, boosts their self-worth, I'm able to show them they are worth looking after their vaccines and looking after their abscess or just showing them there is hope for the future. I think it's pretty self-explanatory, you know.

In order to effectively implement roles and programs such as Stacey's public outreach, healthcare services and governing bodies are required to think "outside of the box" in terms of delivery and services offered, keeping in mind ways to improve accessibility and visibility of said services. Stacey's role at the ASO is described as the first instance in which Regional Public Health has brought these services out into the community and credits her management for enabling her to try new ideas and programs. Through constant evaluation and reworking these outreach services can provide a level of care that is not attainable through fixed-site clinics and health centres, lessening the overall burden on the healthcare system and ensuring the health of at-risk populations such as the NEP' clients. Not only does this allow less dangerous illnesses such as abscesses and infections to be treated before they become emergency situations, but it fosters trust in healthcare systems which can provide added benefit over time through more frequent doctor visits and self-empowerment/care.

Political Change Since the 2015 Federal Election

In the interest of shedding light on the developing political climate in which harm reduction work is performed, participants were asked if they experienced any changes regarding harm reduction practice and policy, either directly or indirectly. This could relate to resource availability, funding changes, legal challenges, or anything else participants could think of in

relation to the election. Overall, workers experienced little or no change in their work, the supplies they have access to, or other factors relating to their jobs and clients. However, some expressed that they noticed a change in public and political discourse relating to harm reduction since the federal election:

> **Adrian**: I think there's been a lot more buzz about safer injection sites and that sort of stuff. Locally not so much. I mean you see more stuff in the news around fentanyl, heroin, Naloxone and that sort of stuff which is great but I would say no, not really.

This demonstrates the general extent to which workers experienced change since the recent election, if they reported any at all. While there are more stories being reported in the news media, such as the pop-up sites and new SISs mentioned in the introduction of this work, in terms of the actual policy and practice of the NEP there has been little change. There was one exception regarding Naloxone and Safer Injection Sites:

> **Andrew**: Toronto is about to get three [Safer Injection Sites], Hamilton is applying. That has all happened since the election. In terms of Naloxone, this is more on a provincial level, access has opened up, so now the pharmacies are doing it, it will continue to expand which is a wonderful thing. I have just kind of assumed that coincided with the election though it would make sense that it did. So more access there with the pharmacies, us being able to distribute to anyone who is a good fit instead of only people who are using. Yeah I feel like there's been a pretty big shift.

Here workers indicate that there is more support from the public and politicians for more radical harm reduction implementations such as SISs and the wide proliferation of anti-overdose drugs. This could in theory lead to benefits for the NEP as well — better public image of harm reduction could translate to more community partners, donations from the general public, more volunteers, and an increase in satellite sites willing to act as an outlet for harm reduction supplies. Participants who shared this view spoke of the political climate being less restrictive and more open to new ideas and strategies for implementing harm reduction services and expanding on existing ones.

Inclusivity, Accessibility, and Cultural Outreach

As part of the effort to include an intersectional theoretical perspective in this project, participants were asked whether they understood the ASO to be inclusive, and what this inclusivity meant to them. Critical and feminist research in the past has been utilized for investigating the "social and cultural factors that shape the lives of people who use legal and illegal drugs" (Boyd et al 2008, p.2) and can thus be applied to the NEP for similar reasons. By investigating the values of this particular organization and the individual workers who comprise it, the social and cultural factors which contribute to the social construction of the NEP are elucidated. Exploring these social and cultural factors and, in turn, how they are manifested within the NEP can illuminate the ways in which the workers and organization seek to include and represent certain vulnerable social groups. This is significant to explore because these manifestations — such as forms of representation, efforts to make services more accessible to certain groups, and cultural awareness — can affect service provision in many ways.

To the participants, inclusivity had a wide variety of understandings ranging from pertaining to race, gender, and sexuality, to referring to volunteers and the amount they are included within the inner workings of the ASO. The organization was described as very open with little discrimination, with this being part of the organization's mandate and philosophy:

> **Stacey**: I've never seen anybody turned away, I think one of their big mandates is inclusion. Everybody is welcome, there's programs for different people, the GLBT population, the sex trade population, the IV drug using population, the smoking drugs population, you know they're all welcome. And if they don't have services for a particular client they are very open to helping that client to link up with other services. So it's not like "oh no you don't fall into our category, we can't help you" and shut the door behind them. They bring them in, they link them up with another outreach worker or agency that can help them.

This data makes it clear that workers strive to accommodate every client in any way that they can, making them feel comfortable and valued as people. One common phrase used to describe this was that “drugs don’t discriminate” and that all clients irrespective of their social group need to be served with respect.

More specifically, the ASO has made efforts to improve representation of more marginalized groups. First, an African-Caribbean community worker was hired specifically to work with racialized groups in order to provide someone who may be more familiar with and relatable to their specific experiences and needs. Furthermore, non-English language services are available in the situation that a non-English speaking person requires resources or service but is incapable of asking in English. Second, cultural and social training was provided to employees to foster a better understanding of issues pertaining to race, gender, and sexuality:

> **John**: There's lots of training available, there's conversation always going on between co-workers about, you know, if there's a transgender person that starts volunteering or working or something people are very respectful about “how do you want to be addressed” and “how do you want this”. Next week I think we have a training on cultural competency but it's not just on race, it's about the trans community, the LGBTQ injection drug users. I think it's part of the whole philosophy of the agency.

> **Hannah**: I mean certainly we have a lot of people here who are gay so we sort of have that gay-straight thing but we also have a number of our clients who are trans and certainly because we’ve got the NEP we’re very inclusive when it comes to people who are living with addictions. As I said we’re working much harder now on working with people who’ve got mental health issues as well.

This testimony shows how the ASO has made an effort in order to ensure that its employees are trained and knowledgeable intersectionality in order to better serve its clients and foster trust. Third, information and literature is on display and available to people of specific cultures and religions as well. In figure 5 there are multiple examples of this, with the first two pertaining to

Indigenous peoples, the third for Muslims, and the fourth containing harm reduction information in English, French, Spanish, Swahili, Arabic, and Amharic. Lastly, programs are made available pertaining to sex workers specifically in order to accommodate their needs and demonstrate solidarity with their struggles.

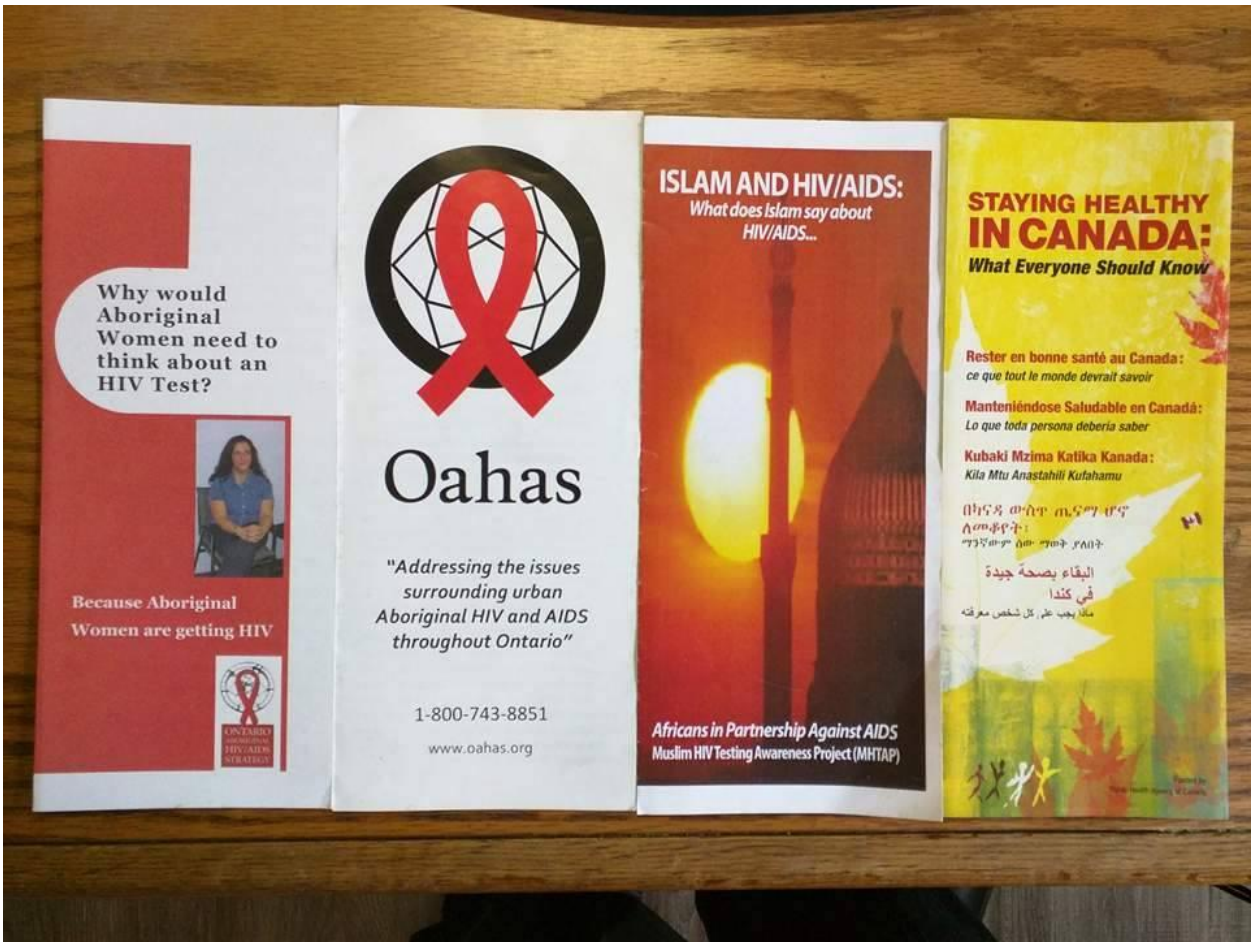


Figure 6 - Multiple Resources Available at the ASO

These multiple strategies as a way to foster a space of inclusivity are important for the provision of effective service that reaches clients beyond the majority Canadian demographic that is white and either Christian or unaffiliated. While NEPs may seem like depoliticized spaces, which many respondents claimed, “anyone could access,” their specific training and the availability of these culturally and religiously specific materials demonstrate how the creation of

this accessible space is deliberate and must be generated rather than assumed. These efforts ultimately make their services more accessible and appear more welcoming to populations that may otherwise avoid these spaces and not utilize their resources.

Conclusion

This chapter engages with and presents the data collected for this project, organized into thematic categories. While there was a wide array of data generated through the interview process, certain themes, concepts, and evidence are significant in that they are not yet present in the literature or develop on past research which is sparse in terms of investigation.

Regarding policy and politics, the 2015 Canadian Federal Election had little direct effect on the NEP itself, with much effort being focused on SISs rather than existing harm reduction programs. Police relations between the NEP and law enforcement complex, with some cooperation occurring but with radically different mandates there is still a tension between the two entities that can cause issues. A novel policy and organizational effort within the NEP that was not observed in the literature was the use of specific print materials in order to make the service more accessible to people of different cultures, religions, sexuality, and languages.

Emotional labour was another aspect of harm reduction work which was largely absent from the literature. The rewarding aspects of the job, the emotional strain from hearing traumatic stories and providing support, and frustration with lack of services to refer to are important parts of harm reduction work to the participants. Perhaps more significant are the practices they use to cope with these sometimes difficult emotional issues — self-care, compartmentalizing and leaving work at the office, and debriefing — help the workers to perform competently and keep from becoming exhausted.

Lastly, information about the clients and the relationship the workers share with them was a topic of vital importance. Specifically, the necessity of client trust can not be overstated in that if there was no trust, or if the relationship between clients and the NEP were damaged — such as when Family and Child Services were called by a satellite site — then this could result in a massive decrease in clients who frequent the site. In contrast with avoiding damaging the relationship, the NEP used techniques to foster trust such as displaying client artwork, having a community newsletter and information board, and using ambassadors to reach clients who may not be comfortable utilizing the site. All this is significant for the purposes of further research which can further investigate how trust can be fostered by the NEP and workers in order to create a more effective program.

Chapter 5 - Discussion and Conclusions

Enclosed in this final chapter is a discussion relating and comparing the findings of the study to the literature on harm reduction and the workers that implement it. Additionally, the findings will be contextualized by and related back to the political economy of health approach outlined in the third chapter. Furthermore, limitations of this study and ethical issues it raised will be engaged with in order to provide transparency and highlight what can be improved upon by future research. Lastly, a summary of the research project's purpose and significance, methodology, and general findings will be provided, in addition to highlighting areas of future research to be explored.

Discussion

According to the political economy of health approach, health and healthcare are produced in relation to political and economic systems, in addition to the unequal distribution of resources and power which accompany these systems. Our current economic system of neoliberal capitalism centres market and economic forces as the dominant institution around which society is to be constructed, allows business interests to determine public policy related to health, and espouses the neoliberal individual as the ideal citizen type to be strived for by all people. In light of this, it is argued that harm reduction and NEPs in the Niagara Region act largely as a site of resistance to neoliberal restructuring while still being constrained by it. First, these services are non-profit, free to access and utilize, and funded in part by the public as opposed to corporations. This directly contradicts the neoliberal mandate that all services should be operating in order to generate a return on investment, and that such an approach will be the most efficient in terms of operation and resource allocation. The availability of free harm

reduction supplies reduces the responsibilization of the individual in that they are not expected to have capital to exchange for services and supplies. Furthermore, the increased access to these supplies through satellite sites and the mobile van, despite the lack of profit to be made, demonstrate further that the burden of making services accessible rests with the organization rather than the individual client. Lastly, that this service is funded by the public through the provincial government as opposed to private sponsors and business interests means that harm reduction and NEPs in the Niagara Region are still entrenched within the nationalized healthcare system and the welfare state in general.

Coburn (2009) states that "despite the fact that literature on social determinants of health evidences the importance of social capital, social cohesion, and *trust* as key contributors to health, neoliberalism has shifted the political economy so that all forms of collective and state action are attacked" (p.41). Not only is the NEP already entrenched as a form of collective action funded by the state, but the trust being built by the workers as healthcare providers further establishes the service as a form of collective and community action. The importance of client trust, and the significance of the client-worker relationship further acts as a site for resistance to neoliberal social relations. In neoliberal theory, the relationship between the client and worker would be a business relationship and little more – a transaction would be made for the supplies which the worker would facilitate, the sale would be documented, and the interaction would then end. However, this is not the case in the NEP as workers must put considerable effort into bonding with the clients, building rapport, and establishing trust in order for the NEP to effectively work and be socially accessible to the highly stigmatized population using their service. This relationship is both important as a site of resistance to neoliberal policy and as a demonstration of its limitations – without the trust being built outside of typical neoliberal social

relations the NEP would not be utilized by clients nearly as much and would ultimately fail in its mandate to provide clean harm reduction equipment and prevent the spread of disease in the community.

This does not however mean that the NEP and the welfare state which funds its endeavours are free from the influence of neoliberal ideology and structuring. The funding which is provided to the NEP is applied for and renewed and is not guaranteed to the organization providing harm reduction services. This funding is based on goals which are themselves influenced by neoliberal ideology – that the program must achieve certain objectives such as high needle return rates, it must be able to demonstrate this concretely through data collection that these objectives are being met, and must follow policy mandated by a neoliberal state which expects compliance. While this may seem desirable for administering an effective program, its flaws quickly surface in practice. Even if the NEP had lower needle exchange rates – simply put that more needles were going out to the public than being returned – and was consequently discontinued, this would not eliminate the need for sterile equipment and the disposal of used needles. Furthermore, compliance to policies which limit the NEP may detriment their initiatives as well, for example, workers reported that many clients expressed a desire to have multiple Naloxone kits, yet they were only permitted to dispense one per visit due to state policy regarding their service.

Neoliberal structuring affects the labour practices of the NEP as well in a way which encourages precarious working conditions. Economic austerity, or the practice of reducing public spending in the hopes of ameliorating government deficit and debt, financial liberalization and privatization, and the creation of "flexible" labour markets, is a popular strategy of state restructuring for proponents of neoliberalism (Harvey 2007). In Canada, this resulted in

"increased insecurity in non-profits through low pay, job insecurity, stress, unpaid overtime hours, work intensification, the erosion of discretion, deskilling and casualization through part-time and temporary work" (Cunningham, Baines, Shields, & Lewchuk 2016, p.458). Within the NEP researched for this study, this effect was seen through the extensive use of volunteer labour to supplement the general workforce to perform reception duties, attending the NEP itself, or assisting with outreach services. Further compounding this, some of the workers were hired on short-term contracts which had to be renewed periodically, rather than being guaranteed full time secure positions. Lastly, the reliance on peers for the construction of SCUKs through the peer program, while offering valuable insight into the lives of participants, is another example of the reliance on precarious and poorly paid work instead of secure, state funded employment for clients who contribute to the very program they frequently utilize.

While much of the ASO's employees' work replicates what is in the literature — such as the provision of needles, ancillary supplies such as tourniquets, lip balm, sterile water, spoons, and SCUKs — there is much that can be considered novel in the sense it is not mentioned in the literature or is a unique strategy that the workers created themselves. For example, using food grade PVC piping to create their own mouthpieces for SCUKs in order to reduce costs that would be associated with purchasing prefabricated mouthpieces is one case study that is absent from the literature. Furthermore, participants provided valuable perspective on aspects of their work and issues they engage with that were either outlined briefly in the literature or not at all. This includes, but is not limited to, the services they provide, awareness of public opinion, their engagement with the police, and their emotional labour and boundary negotiation. This in-depth qualitative perspective offers a chance to investigate these themes in way that is not based solely

on quantitative data and surveys and is practical as opposed to theoretical, thus able to better inform developing theory.

As noted, many services the ASO offers demonstrate the standard practice as outlined in the literature such as dispensing needles and receiving used ones, however there are certain areas worth highlighting. While seemingly mundane, the client ID system they utilize allows the workers some measure of data with which they can track drug and supply usage trends and predict what resources they may need in the future. While there is no way to confirm the identities used by clients as "true" (no official government-issued identification is asked for) as long as each client consistently uses the same client ID then the data can illustrate accurate usage patterns down to the individual person, even tracking usage as small as a single needle. Gindi et al (2009) claim that collecting this sort of information, what they refer to as "retention data" (p.93), is advantageous in that it can provide information on the relationships between workers and clients. Furthermore, it provides evidence to the efficacy of certain service models and tactics, and allow new strategies to be implemented in order to reach high risk users. While this may benefit the organization in terms of refining their program, it must be noted that this data is largely used to evidence that goals set by the neoliberal state are being achieved – that exchange rates are high, that naloxone kits are being used as they are dispensed, and ultimately that a return on investment is being accomplished – and that healthcare funds being used in harm reduction services are reducing the burden on other sectors such as emergency and long-term care services. Without demonstrating this with the data collected the state would likely not renew their funding, despite the cost in human health that would inevitably result.

Their unrestricted exchange policy is also noteworthy, as it allows clients to freely access resources without having to always bring back used equipment, and are thus more likely to avoid

sharing or the re-use of needles and other materials. This is significant because research has shown that certain exchange policies can increase the rate of re-use and sharing of equipment among the intravenous drug user (IDU) community, and by extension the general public as well (Sherman et al 2015). These policies include the one-to-one policies of many NEPs in the United States in which users need to bring in one needle to receive one sterile needle. Beyond being medically evidenced, the unrestricted policy as opposed to one-to-one policy acts as a form of resistance to the responsibilization of the individual that is foundational to the neoliberal state's logic. Rather than clients being expected to keep track of their used needles in perfect form all of the time and punishing them when they do not adhere to this ideal citizen model, the unrestricted system works on an understanding that equipment can break, clients make mistakes, will not always follow program procedure, and will still need new equipment. In this way the program better fulfills its goals by preventing the transmission of disease, whereas the neoliberal one-to-one model can increase the risk of exposure by not dispensing more equipment as a punishment for not having used needles to return. While it may appear that the unrestricted exchange policy further responsibilizes clients by relying on them to keep track of multiple needles, it has flexibility and does not demand and enforce responsibility as the one-to-one exchange does. The former recognizes that lapses in responsibility are inevitable and should be planned for, whereas the latter demands a single type of client who is flawless in their adherence to program protocol, regardless of the reality of clients' situations and the damage this may cause.

In addition to providing sterile needles, both the peer program and on-site nurse services offered by the ASO are beneficial in addition to regularly offered service. The former is similar to the programs offered by the SCORE project in which crack-cocaine users, specifically women, were recruited in order to participate in SCUK making sessions that doubled as a focus

group for research endeavours (Bungay et al 2009). The researchers found that these sessions were integral in creating a safe space for women who use drugs, in addition to allowing participants to share information and build a sense of community. The sessions also provided a wealth of qualitative information regarding their lived experiences, occurrences within their community, and the tactics they utilized in order to live in as marginalized people. From the perspective of an interpretive methodological framework, the information and lived experiences gathered from these peer sessions has value that quantitative data may not be able to provide, and thus are crucial for developing a full understanding of the issues pertaining to harm reduction practices and services, as well as the lives of clients. Not only does the ASO's peer program allow for these benefits but it also helps to funnel some resources back to the clients in the form of an honorarium while being able to provide resources for additional clients. It should be noted however that some staff indicated they would prefer this to be an "official" paid position to provide an additional measure of economic security for those performing the work. This precarious, unregulated and poorly paid work can be considered a result of and in some ways a form of neoliberal restructuring of the workplace in the sense of taking work that previously would be a paid position and reducing it to volunteer work or work that is improperly compensated. Consequently, this leads overall to a decrease in paid work and an increased reliance on volunteers, more time being spent training volunteers than helping clients compared to having a stable workforce, less benefits for workers and clients who could be hired as full-time workers, and overall less social stability for those having to work in a state of precarity.

The on-site nurse, even being present only once a week, was significant in demonstrating to clients that their health was important and worth consideration. In the context of harm reduction, medical professionals are generally only present in SISs and so having even one

present within the NEP setting makes a significant difference in the range of services offered and the amount of people reached by medical professionals. This allows them to act as a point of contact with the public health system so clients can access further medical care if needed, and thus medical issues are engaged with before they become emergency scenarios. This is one advantage of safe-injection sites such as Insite since they have nurses on site not only to help provide direction on injecting but also to provide wound care, as well as "creat[ing] dignified, [and] caring and trusting bonds that build foundations for change through personal empowerment" (Jozaghi and Andresen 2013, p.7). Through the integration of a public health nurse in their service, this helps the ASO to create this same bond between their organization and clients which is vital for effective service. This service is also significant in preventing a number of public health problems, as people who inject drugs are often prone to infections, abscesses, and in some cases more serious illnesses and injuries (Grau et al 2009). Even those who smoke their drug of choice rather than injecting can have "chronic cuts, burns, blisters and open sores inside the mouth and on the lips and gums… through sustained contact with hot smoke and hot metal" (Leonard et al 2008, p.256). Furthermore, relating back to the work of Jozaghi and Andresen (2013) this treatment and attention provides "personal empowerment" (p.7) that is important in both raising the esteem of the clients and building rapport with clients for the NEP. As data shows that public health nurses in British Columbia primarily offer care through fixed site health clinics (85%), the use of NEPs as a location through which to perform public health services is a strategy that could be more widely implemented (Bungay et al 2014). This would allow public health nurses to reach more clients and overcome barriers to accessibility which could restrict or dissuade clients from seeking them out at their clinic alone.

Aside from clients however, workers expressed an interest in improving the rapport of the NEP in relation to the general public as well. As many respondents noted, people in the general public are often unaware of even the existence of the NEP. However, as Adrian claimed, the people who are aware "either strongly agree with it or really strongly oppose it". This coincides with the findings of Strike et al (2014) on changes in public opinion regarding safer/supervised injection facilities. They demonstrate that between 2003 and 2009 public opinion had split both increasingly for and against harm reduction practices, specifically supervised injection facilities, with the number of people holding mixed opinions decreasing (Strike et al 2014). While public opinion is based on many complex factors such as stated goals of the initiative or organization, funding, and location, the authors maintain that "implementation planners may need to target this group [people undecided on their opinion of harm reduction initiatives] specifically to ensure that their opinions do not sway towards opposition" (p.951). While this research focuses on SISs it can reasonably be assumed that these opinions would apply to NEPs given their similar functions and goals and thus ongoing research is required in order to not only gauge public opinion (perhaps specifically for NEPs) but also how these opinions can best be swayed in order to be more amicable to NEPs, SISs, and harm reduction initiatives. Public opinion is of crucial importance for the implementation of future harm reduction programs and the continuation of existing ones. If public opinion were to sway in a negative direction this could dissuade the Canadian government from passing policy and legislation which enables future programs and may affect the general feasibility of continued support for existing ones as well (Strike et al 2014). Furthermore, it could affect services which rely on both public funding and private fundraising in that it could diminish the amount of resources gained. Attention should be given to how public opinion polls are constructed and implemented by government entities who may have

a vested interest in defunding public services such as healthcare for the purpose of neoliberal restructuring, especially with such a politically controversial issue as harm reduction. Furthermore, it must be noted who is consulted as a community expert – for example, are police and conservative entities who are opposed to such programs being approached as expert opinions, or people who use drugs themselves and healthcare workers already working with these individuals? Depending on who is consulted, community and public opinion could be misconstrued and those who find harm reduction initiatives undesirable because they perceive it as increasing crime or lowering property value – a problem often addressed as NIMBY (Not In My Back Yard) – could potentially harm the chances of beneficial harm reduction programs being implemented (Strike, Myers, & Millson 2004).

Participants noted that the police are a significant factor that must be considered in the performance and implementation of harm reduction work, specifically because it can affect the behaviour of their clients in addition to possibly being detrimental to their trust in the NEP when there is a police presence. This can cause clients to avoid the site in addition to warning others to do so as well, could lead to the arrest of clients if they are receiving drug paraphernalia while on parole, and permanently damage the reputation of the NEP. At the same time, police are necessary as a stakeholder because of their presence in the communities serviced by NEPs and their involvement in politics which may affect NEPs (such as membership of committees and status as an "expert" on issues pertaining to law and community security). Workers were adamant about distancing themselves from involvement with the police organizationally — through highlighting the difference in mandates and not having any official connections — and also individually through asking officers in proximity to the NEP to have distance between them and the site in order not to dissuade clients from using services for fear of reprisal. This is in

agreement with the literature, which claims that PWUDs and NEP/SIS clients are disproportionately affected by police practices through searches, confiscations, arrest, and general harassment (Shaw et al 2015, Ivsins et al 2011). Clients were said to be keenly aware of this fact and in an environment where many clients are already wary of involvement with the NEP, police presence nearby could put them in very real danger of being arrested or harassed. Furthermore, police presence acts as a factor making clients averse to utilizing NEP services was espoused both by participants and the literature as well (Strike et al 2002).

The arrest and redzoning of sex workers – denying people access to certain areas – some of whom use the NEP services and other local services such as food banks and employment/social services like Start Me Up Niagara, is a striking example of, as Harvey (2009) stated, the coercive arm of the neoliberal state protecting business interests and repressing individuals to the detriment of their health. Local business owners support the policing of sex workers in the interest of making their locations more appealing and desirable to their consumer base through policing "deviance". Through their arrest and attempted manipulation of these clients' geographical boundaries which clients can access, law enforcement in turn generated a "riskier" environment in which individuals may be more prone to sharing or reusing equipment, are unable to access certain health services, and may not be able to safely dispose of used equipment. The ability to perform outreach – to subvert the expectation that individuals must be responsible for their own access to services – is of critical importance in subverting this risk, acting as a mitigating factor which can alleviate the effects of redzoning and the presence of law enforcement. Through bypassing geographic distances and allowing people to access supplies in the comfort and safety of their own homes this makes service more accessible to clients as opposed to always requiring them to visit a static centralized location.

Lastly, boundary negotiation and the emotional labour invested by harm reduction workers into their practice is noteworthy yet there is little to no data relating specifically to harm reduction workers. There was, however, much existing literature on this topic pertaining to service workers and, more specifically, workers involved in health services. For example, health workers are trained to be cautious about facilitating dual-relationships, while still providing an adequate level of care for their patients (Reamer 2003). Similarly, NEP workers must go beyond widely held views about professionalism by offering counselling, emotional support, and empathizing with clients while still maintaining some semblance of a professional boundary. This is necessary in order to avoid situations where the worker's authority could be abused, such as the worker instead using the clients for emotional support, or the workers' personal life affected if they were to, for example, provide their home phone number to a client. Furthermore, undertaking this counselling and emotional support entails a significant amount of emotional labour on the workers' part, which can be both rewarding and stressful to the workers. Certain factors outlined in the literature, such as stress being caused from excessive workloads and resource availability applied directly to this study as many workers complained that the lack of resources, services, and referral options were a main source of their frustration (Panday & Singh 2016). Crucial in mitigating this stress was the practice of debriefing, defined as staff being able to relay their emotions and experiences off one another in order to contextualize and examine certain events, as well as to find solidarity and support in their coworkers (Peternelj & Yonge 2003). Debriefing was mentioned by multiple participants as a way to talk about and emotionally "unpack" after distressing or traumatic situations, or from hearing about such occurrences in their clients' lives.

One factor that significantly offset the negative and straining aspects of harm reduction work is the rewarding aspects of the labour. Participants were firmly committed to their positions, appreciated the often-warm reception they received from grateful clients, and felt they were a driving factor in the improvement of their clients' lives. Future research directions could investigate whether these emotions and perceptions are similar throughout the harm reduction field, and how they compare to other sectors of work which involve emotional labour. Overall there is much work to be done in researching the emotional labour of harm reduction workers and how this is affected by organizational factors, resource availability, different types of clients, and how previous training and experience may offset negative aspects of this work.

Limitations and Ethical Considerations

During the first conceptualization of this project and throughout the implementation of the research project some limitations were present that must be acknowledged. First, as noted previously, semi-structured interviews were both cost and labour intensive. With each interview participant being offered a $20 gift card as compensation the small budget of the project could only accommodate a single NEP without cost of interviews becoming prohibitive. Furthermore, the time it would have taken to process more than one site worth of data, specifically transcribing and coding, would have likely pushed the project beyond a reasonable time frame. Ultimately, with only a single researcher and a relatively brief time frame for sampling, data collection, transcription, analysing, and writing this means that only a single site could be researched. While it is fortunate for the purpose of performing this research that a single NEP covered the entire Niagara Region and that nearly all workers at the site were interviewed this project could have been improved by asking the same questions to workers in more cities. Particularly, Hamilton

and Toronto would be ideal as they are larger than St Catharines and in comparison, are more highly populated urban centres.

Lastly, while this project strove for the highest ethical standards possible this at times proved a challenge. While data was kept as confidential as possible, the size of the employee pool of the research site proved difficult on occasion to protect the identities of participants without some element of risk being present. Since the number of employees was so small, likely under twenty, there is a chance that some quotations that contained identifying information may have been missed by participants when they reviewed their transcripts. Certain questions were paraphrased in order to remove identifying information, pseudonyms were used, and names used in quotations were purged if mentioned explicitly to keep the respondents as confidential as possible. However, as previously mentioned ethical considerations are an ongoing endeavour, not stopping at approval from the Research Ethics Board, and thus effort was made to ensure that participants were made aware of the material to be included in this project. This proved difficult at times, as during the project respondents' contact information could change, people could take leaves of absences from work, or change jobs and relocate entirely. This experience attests to the ethical complexity involved in qualitative research, and indeed all research.

Conclusion and Future Research

The purpose of this study was to investigate the experiences of harm reduction workers as they relate to their clients, the state, resources offered, and the work itself. This project was undertaken in order to explore an often overlooked aspect in the growing field of harm reduction and sociology of public health, to contribute to the literature, and ideally provide a guide of best practices, areas for improvement, and reveal topics for further investigation. While much literature pertaining to harm reduction focuses on cost-benefit ratios, the supplies offered, and

health benefits/disease prevention, this research endeavour highlights the social and sociological factors that relate to such work as well. For example, a wide array of intersecting oppressions affects the clients involved in harm reduction work, the state and police can significantly affect service provision by their mere presence alone, and personal/professional boundary negotiation involved in the often ignored emotional labour required in this line of work must be balanced against maintaining client rapport and trust.

Theoretically this project was informed by political economy of health, and subsequently critical and interpretivist methodologies. Semi-structured interviews were performed with ten employees who actively worked at or with the ASO providing harm reduction services and resources to the surrounding community. Participants were asked about their work, clients, the political climate in which they operate, and different factors that affect their work such as the police, satellite sites, and cultural/language barriers. Open, axial, and selective coding were undertaken manually in order to analyse and organize the data into common themes and categories for the final findings section.

The findings, while varied, depict an experience that goes far beyond dispensing resources to the public and demonstrates the sometimes intense emotional labour that is performed by harm reduction workers as well as the many barriers they face in their work. Stress, frustration, and burnout are constant factors although many employees described their work as ultimately fulfilling; the workers were passionate about providing a service to the public. They provided accounts of the importance of client trust and how difficult and time consuming this trust is to properly foster, in addition to how quickly it can be disrupted through the actions of the police, or satellite sites if confidentiality is not ensured. Lastly, the participants highlighted novel solutions and practices that could be beneficial to other NEP and SIS locations such as an

on-site nurse, home delivery outreach, their peer program, and a multifaceted strategy for making their services more accessible. This accessibility is achieved through language translation services, cultural outreach, and programs/materials for oppressed demographics such as women, the LGBTQ+ community, immigrants, and racialized minorities.

While the data collected for this project exceeded preliminary expectations in terms of amount and the variety of themes which emerged, there still remains much research to be done on the topic of harm reduction workers and their experiences. Since the interviews were performed, participants have alerted the researcher that certain situations have been changing rapidly with an ongoing opiate crisis in Ontario; the rise of fentanyl contamination has lead to increased usage of Naloxone beyond previously observed rates. Furthermore, given the relatively small geographic area covered by this project many of the questions asked and issues raised here could be applied provincially or even nationally in order to provide further insight to these issues and highlight new and effective ways of performing harm reduction work. Some questions could include: how is emotional strain and frustration coped with by harm reduction workers? How is effective outreach performed and what barriers have arisen? How are boundaries between clients and workers negotiated and how do different strategies affect the work? What is the relationship between workers/organizations and the police, and how do these relationships affect service? How has political change at different levels of government affected harm reduction practice and the proliferation of services? How are marginalized groups such as women, immigrants, LGBTQ+ individuals to name a few, engaged with by the NEP and what strategies are in place to facilitate accessibility if any? Lastly, what is the public opinion regarding NEPs and how has this changed over time?

Throughout this research it has been made apparent that there is a wealth of information to be discovered about the lived experiences and practices of harm reduction workers — in NEPs, SISs, about outreach workers, public health nurses, support workers, frontline staff — all of which will contribute to a better understanding of these projects and programs. This is crucial for not only improving these services but also building a foundation for new strategies in order to combat life or death scenarios such as overdoses, and limiting the spread of disease for the public. It is vital that this research is done with careful effort to engage the participants at every step where possible and to provide in-depth qualitative data in order to expand our understanding of this issue, but also to humanize clients and the workers who aid them. The accounts included within this project, and that research which includes direct accounts from the clients, is paramount in reducing stigma and providing insight to the lives of clients and workers that quantitative numbers can not always accomplish. Arguably, ensuring that these facilities, their workers, and clients are researched is about more than investigating a sociologically interesting topic, it is about ensuring a better quality of life, access to healthcare, and the fundamental dignity of the people who use these services.

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Appendix A - Terms and Definitions

This brief section will outline some of the common terms in harm reduction research and work in order to prepare the reader to properly understand the material covered in this thesis:

AIDS Service Organization (ASO): An organization which provides support and services to those living with HIV/AIDS which may or may not have an attached NEP and related harm reduction programs.

Needle Exchange Program (NEP): A program which aims to supply sterile injection equipment to PWID in an effort to reduce sharing of equipment in order to stem disease transmission. These facilities can operate in multiple different ways and aim to dispose of used needles as well. Additionally, these sites can offer space for counselling, phone referrals, and the storage of supplies if operating within a fixed location (Strike et al, 2002b). These can also be referred to as needle and syringe programmes (NSP).

Point of Care (POC) HIV Testing: A rapid test which can be done in minutes to test for HIV antibodies (Shaw et al 2015).

People Who Inject Drugs (PWID): An alternate term to the traditional Injection Drug User (IDU) used to refer to those who consume drugs via injections (Shaw et al 2015). People Who Use Drugs (PWUD) can be used additionally as blanket term to include those who smoke or inhale drugs nasally as well as those who inject.

Safer Crack Use Kit (SCUK): Kits which include items needed to smoke freebase cocaine or other drugs.

Supervised Injection Site (SIS): A highly targeted harm reduction service that is effective in reaching PWID that require access to clean injection equipment and a safe location in which to inject pre-obtained drugs. Medical staff are on site to treat overdoses and possible injection

related injuries. Can also be referred to as supervised injection facilities (SIF), safer injection sites, or medically supervised injecting centres depending on the context of their use (Shaw et al 2015).

Appendix B - Interview Guide

What this interview is about (Intro)

Staff experiences with:

- Harm reduction materials
- Clients
- Resource availability
- The organization itself
- And the political climate of Niagara in general
- In addition to best practices and barriers related to harm reduction

General Information

- How long have you been with positive living niagara?
- Can you tell me anything about the history of Positive Living Niagara in the Region?
    - [Probes - Streetworks, outreach van, programs aside from needle exchanges and when they started, has the organization grown over the years]
- What would you say your job here is?
    - [Probes - services provided, interactions with clients]
- How does a typical day go for you?

Outreach and Resources

- Tell me about your role in providing services or material supplies to clients...
    - [Probes - what supplies? How are they created/sourced? How are they distributed? Why are they provided? Prompt: Naloxone, SCUKs, peer program]
- Do you feel the you have enough resources at your disposal to help clients effectively?
    - [Probes - if resources are limited, how do they make the most of them? Was this always the case? How do exchange rates work at the site? How has it changed over time?]
- Can you tell me about the outreach services Positive Living does outside of their fixed location?
    - [probes - how is this normally performed and when? Are personal vehicles used? How is this funded? Does the site cover costs of servicing? How is contact made? What is your experience doing this work? Is trust important between the clients and the outreach service?]

Accessability

- What steps does PLN take in order to be an inclusive organization?

- [Probes - services specifically for women, sex workers, language barriers, LGBTQ outreach/services and events, how is PLN an inclusive organization, racial/gender divides, volunteers, areas for improvement]

Staff Perception

- How do you generally feel about the clients you work with?
  - [Probes - stigma, difference from public perception, difficulties with clients, thoughts on abstinence]
- Are there any times you feel your job is stressful?
  - [Probes - lack of resources, overload of work, emotional stress]
- What do you feel is rewarding about your work here?
- How do you feel your work benefits the clients who come to Positive Living Niagara?
  - [improved living situations, health, safety, personal relationships (group support)]
- Have you noticed any change, politically or otherwise, since the recent election?
  - [local effect, national effect on HR, resource availability, legal, resources and restrictions]
- What are your thoughts on supervised injection sites?
  - [necessity of local site, public opinion, feasibility]

Public/Police Interaction and Perception

- How do you think the general public views Positive Living Niagara?
  - (Prompts: changes over time, actual interactions, outreach events, problems, perspective of businesses)
- What is the relationship like between Positive Living Niagara and the police in the area?
  - (Prompts: issues with/harassment, personal interactions, working relationships, areas of improvement over time, differing values, fears of calling 911 in event of overdose, project redlight, police actions and charges interrupting service)

Closing Questions

- Is there any advice you would like to share with other people who work for and with Needle Exchange Programs like Positive Living?
- Is there anything you feel we missed, or should have been asked?
  - (if so and time is up) Would you be interested in a follow-up interview to cover any ground we missed?

Appendix C - Letter of Invitation

Letter of Invitation for PLN STAFF

August 29, 2016

Title of Study: A Preventative Intervention — Staff Experiences Providing Harm Reduction in the Niagara Region
Principal Investigator/ Facility Supervisor: Trent Newmeyer, Associate Professor, Applied Health Science, Brock University
Principal Student Investigator: Mark Omiecinski, Graduate Student, Critical Sociology, Brock University

I, Mark Omiecinski, a graduate student of Critical Sociology at Brock University, invite you to participate in a research project currently entitled **A Preventative Intervention — Staff Experiences Providing Harm Reduction in the Niagara Region.**

The purpose of this research project is to investigate the experiences of staff and volunteers working with Needle Exchange Programs (NEPs) in the Niagara Region, how they view the services offered, and their interactions with clients, the general public, and other organizations. Should you choose to participate, you will be asked to take part in a **one-hour interview** with the possibility of a follow-up interview to cover more ground if you so desire. These interviews will be performed at a **time and place of your choosing** in order to ensure your privacy and convenience. All participants will receive a **20$ Tim Hortons Gift Card for their participation.**

The expected duration of your participation should not go beyond this hour, although you will be contacted and given the chance to review the interview transcript for accuracy. Additionally, if any quotes from you are to be used anonymously, they will be checked with you first. It should be noted that Positive Living Niagara will be the only site to be researched in this qualitative study and that this may limit the level of confidentiality that will be provided. Because of this, data which could be used to identify certain employees or clients will not be included in the final research product, and participants will have an opportunity to review their interview transcript in order to identify any information they wish to exclude. However, if you wish to be identified in the research an opportunity will be provided before the interview to confirm this. Interviews will be recorded using an electronic device to later be transcribed.

This research should benefit both Positive Living Niagara and the academic community by offering a detailed look at the experiences of workers engaged with the operation of a Needle Exchange Program in a region thus far overlooked in existing literature. This could have implications for further research, the creation of policy, and the general reduction of stigma that still unfortunately surrounds these services.

If you have any pertinent questions about your rights as a research participant, please contact the Brock University Research Ethics Officer (905 688-5550 ext 3035, reb@brocku.ca). It should be noted that you are in no way obligated to participate in this study.

If you have any questions or would like to participate in this study, please feel free to contact me (see below for contact information).

Thank you,

Mark Omiecinski - Principal Student Investigator
Graduate Student
289-213-7008
mo10fq@brocku.ca

Trent Newmeyer - Principal Investigator/Faculty Supervisor
Associate Professor
905-688-5550 (ext.5118)
tnewmeyer@brocku.ca

This study has been reviewed and received ethics clearance through Brock University's Research Ethics Board ethics file #15-323

Appendix D - Letter of Consent

Consent Form

Date:
Project Title: A Preventative Intervention — Staff Experiences Providing Harm Reduction in the Niagara Region

Principal Student Investigator (PSI): Mark Joseph Omiecinski (Graduate Student - Critical Sociology)
Department of Sociology
Brock University
289-213-7008

Principal Investigator / Faculty Supervisor: Trent Newmeyer, Associate Professor - Applied Health Science
Department of Applied Health Science
Brock University
(905) 688-5550 Ext.5118

INVITATION
You are invited to participate in a study that involves research. The purpose of this study is to investigate the experiences of individuals working with and for Positive Living Niagara.

WHAT'S INVOLVED
As a participant, you will be asked to participate in a one-hour interview in which you will be asked about your experience working with Positive Living Niagara, in addition to details relating to experience with clients, the public, and region more generally. Participation will take no longer than the single interview, with a possible follow-up interview if time runs short. Interviews will take place at a time and place of your choosing in order to ensure your privacy and convenience, and will be recorded with an electronic device. **Permission has granted by the Program Director for interviews to take place during office hours if you so desire. Participants will be granted a 20$ Gift Card of their choosing for participating in this study, even in the case that participation is withdrawn during or after the interview is completed.**

POTENTIAL BENEFITS AND RISKS
Possible benefits of participation include a chance to share your experience with the academic community. This can be used to promote Positive Living Niagara, harm reduction in general, and generate interest in future research. Furthermore, the results of this study may be used for policy implementation and decision-making in the future.

There are no known or anticipated risks associated with participation in this study as all information will be kept confidential. However, as harm reduction services are predicated on

trust between clients and service providers, sensitive information that could identify clients will be excluded and interviewees will have the chance to review transcripts for any identifying information. Interviewees are encouraged to avoid specific details of cases and the names of individuals and organizations that could be used to identify you or others. Additionally, if interviewees feel they in any way need emotional support after an interview in the case that a distressing topic comes up, numbers for the Ontario Mental Health Helpline (1-866-531-2600) and Distress Center Niagara (905-688-3711) will be available.

CONFIDENTIALITY

The information you provide will be kept confidential unless you wish to be identified. Your name will not appear in any thesis or report resulting from this study; however, with your permission, anonymous quotations may be used.

Shortly after the interview has been completed, I will send you a copy of the transcript to give you an

opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish. Participants will be given up to two weeks after receiving transcripts in order to provide feedback on their interview transcripts before the data are included in the study. However, participants can withdraw their data and participation at any point up until completion of the study (approximately August 2017).

Data collected during this study will be stored under password protection electronically on a personal hard drive. Data will be retained until the end of the study (approximately August 2017) at which point the data and all copies of it will be destroyed. Access to this data will be restricted to the principal investigator (Mark Omiecinski) and the supervisory committee.

Additionally, as Positive Living Niagara will be the only site researched in this study and will be named there are limits on the confidentiality this study provides. Because of this, data which could be used to identify certain employees will not be included in the final research product, and participants will have an opportunity to review their interview transcript in order to identify any information they wish to exclude. However, if you wish to be identified by name and/or position in the research an opportunity will be provided before the interview to confirm this. Otherwise names and specific positions beyond being employed by Positive Living will be excluded. Interviews will be recorded using an electronic device to later be transcribed.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you wish, you may decline to answer any questions or participate in any

component of the study. Further, you may decide to withdraw from this study at any time and may do so without any

penalty or loss of benefits to which you are entitled. In the event of a withdrawal, the participants interview and data will be destroyed and not included in the research study.

PUBLICATION OF RESULTS

Results of this study may be published in professional journals and presented at conferences. Feedback about this study will be available upon completion and can be accessed by contacting the principal investigator.

CONTACT INFORMATION AND ETHICS CLEARANCE

If you have any questions about this study or require further information, please contact Mark Omiecinski or Trent Newmeyer using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University #15-323. If you have any comments or concerns about your rights as a research participant, please contact the Research Ethics Office at (905) 688-5550 Ext. 3035, reb@brocku.ca.

Thank you for your assistance in this project. Please keep a copy of this form for your records.

CONSENT FORM

I agree to participate in this study described above. I have made this decision based on the information I have read in the Information-Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any time.

Name: _____

Signature: _____ Date: _____

I wish to be identified for the purposes of this research ❑

Appendix E - Research Ethics Board Clearance

Brock University
Research Ethics Office
Tel: 905-688-5550 ext. 3035
Email: reb@brocku.ca

Social Science Research Ethics Board

Certificate of Ethics Clearance for Human Participant Research

DATE: 8/11/2016

PRINCIPAL INVESTIGATOR: NEWMEYER, Trent - Recreation & Leisure Studies

FILE: 15-323 - NEWMEYER

TYPE: Masters Thesis/Project STUDENT: Mark Omiecinski
SUPERVISOR: Trent Newmeyer, Jonah Butovsky, Paula Gardner

TITLE: A Preventative Intervention - Staff Experiences Providing Harm Reduction in the Niagara Region

ETHICS CLEARANCE GRANTED

Type of Clearance: NEW Expiry Date: 8/31/2017

The Brock University Social Science Research Ethics Board has reviewed the above named research proposal and considers the procedures, as described by the applicant, to conform to the University's ethical standards and the Tri-Council Policy Statement. Clearance granted from 8/11/2016 to 8/31/2017.

The Tri-Council Policy Statement requires that ongoing research be monitored by, at a minimum, an annual report. Should your project extend beyond the expiry date, you are required to submit a Renewal form before 8/31/2017. Continued clearance is contingent on timely submission of reports.

To comply with the Tri-Council Policy Statement, you must also submit a final report upon completion of your project. All report forms can be found on the Research Ethics web page at http://www.brocku.ca/research/policies-and-forms/research-forms.

In addition, throughout your research, you must report promptly to the REB:

a) Changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
b) All adverse and/or unanticipated experiences or events that may have real or potential unfavourable implications for participants;
c) New information that may adversely affect the safety of the participants or the conduct of the study;
d) Any changes in your source of funding or new funding to a previously unfunded project.

We wish you success with your research.

Approved:

Jan Frijters, Chair
Social Science Research Ethics Board

Note: Brock University is accountable for the research carried out in its own jurisdiction or under its auspices and may refuse certain research even though the REB has found it ethically acceptable.

If research participants are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and clearance of those facilities or institutions are obtained and filed with the REB prior to the initiation of research at that site.